Uniform Data System

2024 MANUAL

Health Center Data Reporting Requirements

HRSA
Health Center Program

For Reports Due February 15, 2025

Bureau of Primary Health Care

Uniform Data System Reporting Requirements for 2024 Health Center Data

Letter from the Associate Administrator

Dear Health Center Program Participant:

The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care supports you in our shared mission to improve the health of the nation's medically underserved communities by ensuring access to comprehensive, culturally competent, quality primary health care services. The success of health centers and their partners to advance quality care and better meet the needs of our over 30 million patients is illustrated in the annual Uniform Data System (UDS) data.

Year after year, health centers have continued to deliver care that is increasingly comprehensive and patient-centered. Health centers have also consistently addressed high-priority public health and health care priorities such as chronic disease management and prevention, mental health, nutrition counseling, and cancer screening.

As we look to the future, health centers are also on the cutting edge of leveraging advances in health information technology to modernize health center performance data to better serve their patients and communities. In 2023, several health centers submitted the first-ever de-identified patient-level UDS data, known as UDS Patient-Level Submission or UDS+. In 2024, health centers will continue to provide legacy UDS submissions, however, we expect that all health centers will report some portions of UDS+ to HRSA to support the successful transition to this new reporting system.

Now and over time, the implementation of UDS+ will allow us to more fully demonstrate the impact of our investments and improve the delivery of high-quality care in communities across the country. Your partnership is a cornerstone of our program, and we are grateful for the collaboration that strengthens our shared mission. Together, we are making a meaningful difference in the health and well-being of our communities.

Thank you,

/James Macrae/

James Macrae
Associate Administrator
Bureau of Primary Health Care

Bureau of Primary Health Care

Uniform Data System Reporting Requirements

For Calendar Year 2024 UDS Data

For help contact: 866-837-4357 (866-UDS-HELP), BPHC Contact Form, https://bphc.hrsa.gov/datareporting/reporting/index.html, or udshelp330@bphcdata.net

Health Resources and Services Administration

Bureau of Primary Health Care

5600 Fishers Lane, Rockville, Maryland 20857

2024 Uniform Data System Manual Contents

Changes to the Reporting Requirements

This section outlines critical reporting instruction changes made **since the original 2024 calendar year** release (May 1, 2024) of this manual. Use the updated manual to prepare and submit the calendar year UDS Report.

- Previous Table 3B, Lines 13-26 are no longer to be reported.

Major changes from the 2023 calendar year reporting to the 2024 calendar year reporting are included at the start of each Table and Form instruction section and highlighted in honeycomb color for ease of locating.

Introduction

This manual describes the annual Uniform Data System (UDS) reporting requirements for all health centers that receive federal award funds ("awardees") under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e), (g), (h), and (i)), as well as for health centers considered Health Center Program look-alikes. Look-alikes DO NOT normally receive regular federal funding under section 330 of the PHS Act (although they may receive funding during public health emergencies, such as COVID-19), but meet the Health Center Program requirements for designation under the program (42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii)). Certain health centers funded under the Health Resources and Services Administration's (HRSA) Bureau of Health Workforce (BHW) are also required to complete the UDS.

Unless otherwise noted, for the remainder of this manual the term "health center" will refer to all the entities listed above that are required to submit a UDS Report.

ABOUT THE UDS

The UDS is a standard data set that is reported annually by each health center and, thus, provides consistent information about health centers. This core set of information for the calendar year encompasses patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues. It is the source of unduplicated data for the entire scope of services included in the grant or designation for the calendar year 2024. If the health center brings services into its scope of project during the calendar year, the health center must include data for the full calendar year in its UDS Report. If the health center brings service delivery sites into its scope of project during the calendar year, the health center must include data from the period after the date of the scope change in its UDS Report.

HRSA routinely reports these data and related analyses, making them available to health centers in HRSA's Electronic Handbooks (EHBs) and to the public through HRSA's data.HRSA.gov website.[1] Please refer to Appendix H: Health Center Resources for resources that may be helpful for completing the UDS Report.

WHAT THIS MANUAL INCLUDES

This manual includes reporting requirements and resources to assist with completion of the UDS Report and that apply to the calendar year 2024 UDS Report **due February 15, 2025**.

[1] In accordance with the Freedom of Information Act (Exemption 4), HRSA's BPHC does not publicly share proprietary business information at the health center level.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

Reporting requirements include the approved UDS changes for the calendar year. The 2024 Program Assistance Letter (PAL) provides an overview of major changes.	**A list of personnel** by service category and by job title who may be eligible to produce countable "visits" for the UDS is shown in Appendix A.	**Issues that affect multiple tables** are addressed in Appendix B. **Reduced denominator** considerations for clinical quality measure (CQM) reporting are provided in Appendix C.
Appendix G describes **UDS Patient-Level Submission (UDS+)** and provides information on accessing the **UDS+ Fast Healthcare Interoperability Resources (FHIR)® Implementation Guide**, for health centers to submit certain UDS tables using HL7® FHIR R4 application programming interface (API).	**Resources** and supports to assist health centers, including links to electronic clinical quality measures (eCQMs), are provided in Appendix H.	**A glossary** of key terms is available in Appendix I. **Acronyms** used throughout the UDS Manual are defined in Appendix J.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

General Instructions

WHAT TO SUBMIT

The UDS includes two parts that health centers submit through the EHBs:

1) All health centers use the Universal Report, which consists of the UDS tables, the Health Information Technology (Health IT) Form, the Other Data Elements Form, and the Workforce Form.

   The Universal Report represents an unduplicated count of all patients served by the health center regardless of funding source; the Grant Report represents a subset of patients reported on the Universal Report who are served under a special population funding authority. Thus, no cell in a Grant Report may have a number larger than the same cell in the Universal Report.

2) Health Center Program awardees that receive section 330 grants under multiple program funding authorities (Community Health Center [CHC] [330(e)] program, Migrant Health Center [MHC] [330(g)] program, Health Care for the Homeless [HCH] [330(h)] program, and/or Public Housing Primary Care [PHPC] [330(i)]) also complete separate Grant Reports.

- The Grant Reports provide data comparable to the Universal Report for Tables 3A, 3B, 4, 6A, and part of Table 5.
- Grant Reports are only completed for the portion of the program that falls within the scope of a project funded under a particular funding authority.
- The vast majority of health centers have a CHC (330(e)) grant and to report a separate grant report would add burden to health centers since the activity makes up a large portion of the Universal Report. Therefore, awardees with grants from multiple 330 programs **DO NOT** submit a separate Grant Report for the scope of project supported under the CHC (330(e)) program.

  Report all the data for any patient who receives services under sections 330(g), (h), or (i) in the proper Grant Report. Include all services provided to these patients regardless of the funding source.

The EHBs reporting system automatically identifies and provides forms for all the reports needed to meet the UDS reporting requirements. Please contact Health Center Program Support through the BPHC Contact Form or at 877-464-4772 if there appear to be errors.

WHAT IS INCLUDED

The UDS includes 11 tables and 3 forms that provide demographic, clinical, operational, and financial data. Health centers must complete the following:

Table	Data Reported	Universal Report	Grant Reports
Service Area			
Patients by ZIP Code Table: Patients by ZIP Code	Patients served reported by ZIP code and by primary third-party medical insurance source, if any	X	Not included in grant reports
Patient Profile			
Table 3A: Patients by Age and by Sex	Patients by age and by sex	X	X
Table 3B: Demographic Characteristics	Patients by race, ethnicity, and language preference	X	X

Table	Data Reported	Universal Report	Grant Reports
Table 4: Selected Patient Characteristics	Patients by income (as measured by percentage of the federal poverty guidelines [FPG]) and primary third-party medical insurance; the number of "special population" patients receiving services; and managed care enrollment, if any	X	X
Staffing and Utilization			
Table 5: Staffing and Utilization	The annualized full-time equivalent (FTE) of program personnel by position, in-person and virtual visits by provider type, and patients by service type	X	Partial (excludes FTE)
Table 5 Addendum: Selected Service Detail Addendum	Mental health services provided by medical providers; substance use disorder services provided by medical and mental health providers	X	Not included in grant reports
Clinical			
Table 6A: Selected Diagnoses and Services Rendered	Visits and patients for selected medical, mental health, substance use disorder, vision, and dental diagnoses and services	X	X
Table 6B: Quality of Care Measures	Clinical quality of care measures	X	Not included in grant reports
Table 7: Health Outcomes	Health outcome measures by race and ethnicity	X	Not included in grant reports
Financial			
Table 8A: Financial Costs	Direct and indirect expenses by service categories	X	Not included in grant reports
Table 9D: Patient Service Revenue	Full charges, collections, and adjustments by payer type; sliding fee discounts; and patient bad debt write-offs	X	Not included in grant reports
Table 9E: Other Revenue	Other, non–patient service revenue	X	Not included in grant reports
Other			
Appendix D: Health Information Technology (Health IT) Capabilities Form	Health IT capabilities, including the use of electronic health record (EHR) information, and social risk factors	X	Not included in grant reports
Appendix E: Other Data Elements Form	Medications for opioid use disorder (MOUD), telehealth, and outreach and enrollment assistance	X	Not included in grant reports
Appendix F: Workforce Form	Health center workforce training and use of provider and personnel satisfaction surveys	X	Not included in grant reports

Note: Grant reports are NOT completed for tables and forms grayed out in this table.

Note: The UDS Support Center is available to provide training, technical assistance, and resources about the UDS data and reporting requirements. Contact the Support Center at **1-866-UDS-HELP,** udshelp330@bphcdata.net, or BPHC Contact Form.

CALENDAR YEAR REPORTING

Who Reports UDS	What is Reported	How to Report	When to Report
• All health centers funded or designated in whole or in part, before **October 1, 2024**, including New Access Point (NAP).	• Approved in-scope activities from **January 1 through December 31, 2024.** • Report even if no grant funds were drawn down for some or all programs during the calendar year.	• Through the Electronic Handbooks (EHBs) starting **January 1, 2025.** • Preliminary Reporting Environment (PRE) and offline tools are available in **Fall 2024**.	• **January 1 through February 15, 2025.** UDS Reports are to be submitted **by February 15, 2025.** • UDS Report reviews are conducted and necessary revisions are made from **February 15 through March 31, 2025**.

The UDS is a calendar year report. Health centers—including all those whose designation or funding begins, either in whole or in part, after January 1—must report in-scope activities for the entire calendar year. Similarly, health centers with a fiscal year or grant period other than January 1 to December 31 will still report on the calendar year, NOT on their fiscal or grant year.

If an entire look-alike program became funded and converted to a 330 awardee **before** October 1, 2024, report only an awardee UDS Report for the year.

Health centers whose designation or funding ends during the year should contact Health Center Program Support via the BPHC Contact Form or at 877-464-4772 to clarify their reporting requirements.

No UDS Report is filed if the health center was funded or designated for the first time **on or after** October 1 of the calendar year.

IN-SCOPE REPORTING

All health centers must submit data that reflects all activities in the HRSA health center scope of project, as defined in approved applications and reflected in the official Notice of Award/Designation.

For organizations that operate programs and/or service delivery sites that are out of scope, limit the reporting to the approved scope of project only.

DUE DATES AND REVISIONS TO REPORTS

The period for submission of complete and accurate UDS Reports is January 1 through **February 15, 2025, 11:59 p.m. local time**.

From February 15 through March 31, 2025, a Health Center Program UDS Reviewer will review your report and, as needed, assist you in ensuring that reported data adheres to reporting requirements. The UDS Reviewer sends communications and data change requests through EHBs via a non-HRSA.gov email address to the health center contact listed in the EHBs. Communicate directly with the assigned UDS Reviewer during this time to address questions they have raised. It is critical to address questions raised by your UDS Reviewer within the timeframe assigned in order to meet the final submission timeline. Final, corrected submissions are due no later than March 31, 2025.

HRSA may grant a reporting exemption under extraordinary circumstances, such as the physical destruction of a health center. Health centers must request such exemptions directly from HRSA's BPHC via the BPHC Contact Form or at 877-464-4772.

HOW AND WHERE TO SUBMIT DATA

All health centers are to submit a full UDS Report within EHBs by February 15, 2025. This will be the official submission of record for 2024 reporting. To log in to the EHBs, use your Login.gov account and two-factor authentication. Visit the EHBs Help and Knowledge Base for more information on Login.gov.

In addition to an aggregate UDS Report submission within EHBs, health centers submit certain de-identified patient-level data (UDS+) using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) standards version release 4 (R4) for UDS, for the data elements on the following tables:

- Patients by ZIP Code Table
- Table 3A: Patients by Age and by Sex
- Table 3B: Demographic Characteristics
- Table 4: Selected Patient Characteristics
- Table 6A: Selected Diagnoses and Services Rendered
- Table 6B: Quality of Care Measures
- Table 7: Health Outcomes

Health centers will submit UDS+ data through (bulk) FHIR R4 APIs, using the UDS+ FHIR Implementation Guide (IG) as described in Appendix G. Details on the minimum submission requirements will be announced on the UDS Modernization Initiative and the Health Center Program Community[2] websites. To learn more about UDS+, please refer to the FAQ for the General Instructions.

Health center personnel need a username and password to log into the EHBs, which are then used to access, complete, and submit the health center's UDS Report. The EHBs supports the use of standard web browsers[3] and provides electronic forms necessary to complete the Report. The PRE[4] provides early access to the EHBs and is available in the fall. This allows health centers to:

- enter available UDS data,
- identify potential data reporting problems, and
- make use of additional preparation time to compile UDS data.

To facilitate a team-based approach, there are also offline reporting templates available within the EHBs. For more information on these tools, visit the UDS Training and Technical Assistance webpage.

Health centers are required to designate one person as the UDS contact. The UDS contact receives all communications about the UDS Report. This person is responsible for ensuring that corrections to the report are made, explanations of accurate data reported on the UDS tables are clear, and the report is submitted according to set deadlines. **Be sure the UDS contact information in the EHBs is current to ensure receipt of important UDS-related communications.**

Health centers grant individual personnel "view" or "edit" privileges in the EHBs. These privileges apply to the whole report, not just specific tables. Health centers may give edit privileges to several people, each using separate login credentials. Health center personnel with EHBs access can work on the forms in sections, saving interim or partial versions online as they work and returning to complete them later.

The EHBs saves user progress until the health center completes all tables, runs system checks on the data, and makes a formal submission. The chief executive officer (CEO) or project director usually submits, but they may delegate the authority to someone else by designating an alternate in the EHBs. At the time of submission, the UDS requires the submitter to acknowledge that the health center reviewed and verified the accuracy and validity of the data. Submit only completed reports into the EHBs. To ensure accuracy, the EHBs checks for potential inconsistencies or questionable data. The system provides a summary of which tables are complete and a list of audit questions. Health center personnel must address each of the data audit findings, even if the audit question

[2] Login credentials are required. Users may request access through the Health Center Program Community.
[3] While most web browsers should work with the EHBs, it is certified to work with the browsers mentioned in the EHBs' recommended settings, which are available on the EHBs website.
[4] Data present in the PRE on December 31 are automatically transferred to the annual UDS reporting environment, which opens January 1.

does not appear to apply to their health center's unique circumstances. If personnel believe the data are correct as submitted, they should clearly explain any unique circumstances with the yearly UDS submission.

Failure to submit a timely, accurate, and complete UDS Report by February 15, 2025, 11:59 p.m. (local time) may result in a condition being placed on your grant award. Additional restrictions, including the requirement that all drawdowns of Health Center Program grant award funds from the Payment Management System (PMS) have the prior approval of the HRSA Division of Grants Management Operations (DGMO) and/or limits on future funding (e.g., base adjustments), may also be placed on your grant award.

Note: Retain health center UDS reporting backup documentation and files for a minimum of 1 year or through a date determined by the health center.

Please refer to Appendix H: Health Center Resources for resources that may be helpful for completing the UDS Report.

FAQ FOR THE GENERAL INSTRUCTIONS

1. **Do we report *only* the services provided to patients using HCH, MHC, or PHPC grant funds on the Grant Report?**

   No. Include activity for all patients described in the approved HCH, MHC, or PHPC grant scope of project, regardless of the funding source. For example, if patients experiencing homelessness receive medical services in the 330(h)-supported homeless medical van, report this activity on the Homeless Grant Report tables. If patients experiencing homelessness receive dental services at the clinic, where 330(h) funds are not used, this activity would also be reported on the Homeless Grant Report tables regardless of the dental funding source.

2. **When do we complete a Universal Report and when do we complete a Grant Report?**

   In summary, health centers that receive funds under only one of HRSA's BPHC Health Center Program awards complete the Universal Report and no Grant Reports (CHC only, HCH only, MHC only, or PHPC only). Health centers funded through multiple of HRSA's BPHC funding authorities complete a Universal Report for the combined projects and a separate Grant Report for activity covered by their MHC, HCH, and/or PHPC program grant(s), but not their CHC program grant.

   Examples include the following:

   - A CHC awardee that also has HCH funding completes a Universal Report for all in-scope activity and a Grant Report for activity under the HCH program, but it does NOT complete a Grant Report for the CHC funding.
   - A CHC awardee that also has MHC and HCH funding completes a Universal Report, a Grant Report for the HCH program, and a Grant Report for the MHC program.
   - An HCH awardee that also receives PHPC funding completes a Universal Report and two Grant Reports—one for the HCH program and one for the PHPC program.
   - An HCH awardee that receives no other Health Center Program funding will file a Universal Report and will NOT file a Grant Report.

3. **We had a service delivery site that closed during the calendar year and is no longer in-scope. Do we report data from the service delivery sites or services that are removed from scope of project in the UDS Report?**

   Yes. If services or service delivery sites are removed from your scope of project during the calendar year, report on all activities (visits, personnel, revenue, etc.) up until the date they were acknowledged as being removed from the change in scope (CIS).

4. We added a new service delivery site to our scope of project. What should we do to report the activity of this new service delivery site on the UDS Report?

Health centers must submit data for all in-scope activities as reflected in the official Notice of Award/Designation when a new service delivery site is added. If your health center added a new service delivery site either through a CIS request or through an NAP award, you will be required to submit data for in-scope activities based on your CIS approval date and/or NAP site implementation date.

5. Is activity at a non-approved service delivery site included on the UDS Report?

No. Only report services provided at your health center's approved service delivery sites (e.g., clinics, schools, homeless shelters, as listed on Form 5B) or in other locations that DO NOT meet HRSA's site criteria but are included in the health center's scope of project (e.g., hospitals, nursing homes, extended care facilities, patient's home), as shown on Form 5C.

6. What is UDS+?

The UDS Patient-Level Submission (UDS+) is a redesigned section of the UDS Report that enhances existing patient-oriented tables (Patients by ZIP Code Table and Tables 3A, 3B, 4, 6A, 6B, and 7), reported in aggregate at the health center level, with de-identified patient-level data. For the 2024 UDS Report, there will be a minimum submission requirement of patient-level data reporting. Details on the minimum submission requirements will be announced on the UDS Modernization Initiative and Health Center Program Community[5] websites.

This reporting will help health centers and HRSA better understand challenges and successes with data submission and the impact of patient-level reporting on final UDS Reports. Once fully implemented, UDS+ aims to advance the utility of UDS data and to reduce the annual reporting burden by aligning with interoperability standards and reporting requirements used across the U.S. Department of Health and Human Services and the health care industry.

UDS+ data will be reported to HRSA using FHIR® R4, which is a next-generation interoperability standard created by the standards development organization Health Level Seven (HL7®). FHIR R4 is designed to enable health data, including clinical and administrative data, to be quickly and efficiently exchanged.

The UDS+ FHIR Implementation Guide (IG) defines the set of rules by which health centers can report the UDS+ data to HRSA with de-identified patient data using FHIR R4 APIs. The UDS+ FHIR IG provides well-defined capability statements, FHIR R4 operations, FHIR R4 profiles, FHIR R4 extensions and terminology needed to successfully implement UDS+.

Additionally, the UDS+ FHIR IG will align HRSA reporting requirements with the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS) regulations to the extent possible.

[5] Login credentials are required. Users may request access through the Health Center Program Community.

Instructions for Tables That Report Visits, Patients, and Providers

Health centers serve many individuals in different ways. NOT all individuals, encounters, and health center personnel are reported in the UDS Report. The following section defines countable visits, patients, and providers for the UDS.

COUNTABLE VISITS

Visits determine who to count as a patient on the Patients by ZIP Code Table and Tables 3A, 3B, 4, 5, 6A, 6B, and 7. Report visits by type of provider on Table 5 and for selected diagnoses and selected services on Table 6A.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

Countable visits are encounters between a patient and a licensed or credentialed provider who exercises independent professional judgment in providing services that are:

- documented,
- individual,[6]
- in-person or virtual.[7]

Count only visits that meet all these criteria.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

Services must be provided by an individual classified as a "provider" for purposes of providing countable visits. Not all health center personnel who interact with patients qualify as a provider, and not all services by a provider are countable visits. See Services and Individuals NOT Reported on the UDS Report. Appendix A provides a list of health center personnel and the usual status of each as a provider or non-provider for UDS reporting purposes.

Visits provided by contractors and **paid for by or billed through the health center** are counted in the UDS if they meet all other criteria. These include migrant voucher visits and outpatient or inpatient specialty care associated with an at-risk managed care contract. In these instances, if the visit is not documented in the patient's health record, a summary of the visit (rather than the complete record) must appear in the patient's health record, including all appropriate documentation and coding. Generally, at a minimum, this will include procedure and diagnosis codes.

Below are definitions and criteria for reporting visits. Table 5 provides further clarifications. See Clinic Visits, Column B.

[6] An exception is allowed for behavioral health visits, which may be conducted in a group setting.

[7] Only interactive, synchronous audio and/or video telecommunication systems that permit real-time communication between a distant provider and a patient may be considered and coded as telemedicine services. The term "telehealth" includes telemedicine services but encompasses a broader scope of remote health care services. Telemedicine is specific to remote clinical services, whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

Documentation

Health centers must record the service and associated patient information, in print or electronic form, in a system that permits ready retrieval of current data for the patient. The patient health record does not have to be complete with all details of the service to meet this standard.

Independent Professional Judgment

Providers must be acting on their own, not assisting another provider, when serving the patient.

Independent professional judgment is the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers.

Behavioral Health Group Visits

Behavioral health (mental health or substance use disorder) visits are the only type of visit that may be counted when conducted in a group setting. A health center may count visits by a behavioral health provider who provides services to a group of patients simultaneously only if the service is documented in each patient's health record.

Examples of "group visits" include family therapy or counseling sessions, group mental health counseling, and group substance use disorder counseling where several people receive services that are documented in each patient's health record.

Other considerations:

- The health center normally records applicable charges for each patient, even if another grant or contract covers the costs.
- If only one patient is billed (for example, when a family member who is not the patient participates in a patient's counseling session), count the visit for only that one patient.
- DO NOT count group medical visits.

Location of Services Provided

A visit must take place in health centers' approved service delivery sites (e.g., clinics, schools, homeless shelters, as listed on Form 5B) or in other locations that DO NOT meet HRSA's site criteria but are included in the health center's scope of project (e.g., hospitals, nursing homes, extended care facilities, patient's home), as referenced on Form 5C. In addition, virtual visits may occur from other locations. See instructions for Virtual Visits.

Inpatient visit considerations:

- Only count one inpatient visit per patient per day, regardless of how many clinic providers see the patient or how often they do so.
- Visits also include encounters with an existing patient who has been hospitalized, when health center medical personnel "follow" the patient during the hospital stay as the provider of record or when they provide care to the patient on behalf of the provider of record. This applies when the health center pays their medical personnel who "follow" patients (or insurance) for the specific service.
- When a patient's *first* encounter is in a hospital, in respite care, or in a similar facility that is **not specifically approved in Form 5B** as a service delivery site under the scope of the Health Center Program, neither the patient nor any of the services at the facility for that patient are counted in the UDS.

Counting Multiple Visits by Category of Service

Multiple visits may occur when a patient has more than one visit with the health center in a day (in-person and/or virtual).

Count only one visit per patient per service category per provider per location in a single day, regardless of the types or number of services provided or where they occur, as described in the table that follows.

Other considerations:

- If multiple medical providers in a single category deliver multiple services to a patient on a single day, count only one visit, even if third-party payers may recognize these as separate billable services. This is typically credited to the provider performing the highest level of or most care, although the health center needs to make this determination for itself.
- Count two visits in a scenario in which services are periodically provided to a patient by two **different providers** of the same service category type who are located at two **different service delivery sites** on the same day. This permits patients who are in challenging environments to receive services outside the health center from a licensed or credentialed health center provider and receive services again on the same day at the health center from a different licensed or credentialed provider.
- A virtual visit may count as a separate visit when a patient has another visit on the same day only if the providers are different and the assigned service delivery location of each provider is different.

Maximum Number of Visits per Patient per Day per Service Category at the Same Service Delivery Site

# of Visits	Service Category	Provider Examples
1	Medical	physician, nurse practitioner, physician assistant, certified nurse midwife, nurse
1	Dental	dentist, dental hygienist, dental therapist
1	Mental health	psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, other licensed or unlicensed mental health providers
1	Substance use disorder	alcohol and substance use disorder specialist, psychologist, social worker
1 for each provider type	Other professional	nutritionist, podiatrist, speech therapist, acupuncturist
1	Vision	ophthalmologist, optometrist
1 for each provider type	Enabling	case manager, health educator

PATIENT

Patients are people who have at least one countable visit during the calendar year. The term "patient" applies to everyone who receives clinic (in-person) or virtual visits, NOT just those who receive medical or dental services.

The Universal Report includes all patients who had at least one visit during the calendar year within the scope of project supported by the health center grant or designation.

- Report these patients and their visits on Tables 5 and 6A for each type of service (e.g., medical, dental, enabling) received during the calendar year.
- On the Patients by ZIP Code Table, on Tables 3A and 3B, in each section of Tables 4 and 5, and for each service on Table 6A, count each patient once and only once. This applies even if they received more than one

service (e.g., medical, dental, enabling) or received services supported by more than one program authority (i.e., section 330(g), section 330(h), section 330(i)).

For each Grant Report, patients reported are those who had at least one countable visit during the calendar year within the scope of project activities supported by the specific section 330 program authority, even if the specific service is not paid for by the grant. The number of patients reported in any cell on the Universal Report includes all patients reported in the same cell in the Grant Report.

Services and Individuals NOT Reported on the UDS Report

Some services **DO NOT count as a visit** for UDS reporting, even though they are critical to the overall provision of care to an individual or a community.

Someone who **only** receives one of the services described below is not a patient for purposes of UDS reporting.

If an individual receives **additional services** that require independent professional judgment from a health center provider and those services are documented, they should be considered a patient of the health center.

The following situations are NOT countable visits:

Health screenings or outreach services

- Do not count screenings (e.g., COVID-19, blood pressure, diabetes) as countable visits, including:
  - Information sessions for prospective patients; health presentations to community groups; information presentations about available health services at the center; services conducted at health fairs or schools; immunization drives; services provided to groups, such as dental varnishes or sealants provided at schools; hypertension or diabetes testing; or similar public health efforts that frequently occur as part of community activities that involve conducting outreach or group education.

Group visits

- Do not count visits conducted in a group setting, except for behavioral health group visits.
  - The most common non-behavioral health group visits are patient education or health education classes (e.g., people with diabetes learning about nutrition).

Tests and other ancillary services

- Do not count services required to perform such tests, such as drawing blood or collecting urine, and other ancillary services, including:
  - Laboratory tests (including COVID-19, purified protein derivatives [PPDs], pregnancy, or Hemoglobin A1c [HbA1c]).
  - Measuring and imaging (including blood pressure, height, weight, sonography, radiology, mammography, retinography, or computerized axial tomography).

Dispensing or administering medications

- Do not count dispensing medications, including dispensing from a pharmacy or administering medications (such as buprenorphine or warfarin).
- Do not count giving any injection (including for immunizations, vaccines, COVID-19, flu, allergy shots, or family planning), regardless of education provided at the same time.
- Do not count providing narcotic agonists or antagonists or mixes of these, regardless of whether the patient is assessed at the time of the dispensing and regardless of whether these medications are dispensed regularly.

Health status checks

- Do not count follow-up tests or checks (such as patients returning for HbA1c tests or blood pressure checks).
- Do not count wound care (which is follow-up to the original primary care visit).
- Do not count taking health histories.
- Do not count making referrals for or following up on external referrals.

Services under the Women, Infants, and Children Program

- Do not count a person whose only contact with a health center is to receive services (including nutrition) under a Women, Infants, and Children (WIC) program.

PROVIDER

A provider exercises independent professional judgment in the provision of services rendered to the patient, assumes primary responsibility for assessing and/or treating the patient for the care provided at the visit, and documents services in the patient's health record.

- Only one provider receives credit for a visit, even when two or more providers are present and participate.
- If two or more providers of the same type share the services for a patient, only one provider receives credit for a visit (see Counting Multiple Visits by Category of Service).
- In cases where a preceptor (or attending physician) is following and supervising a licensed resident, the resident receives credit. (See Appendix B for further instruction on counting interns and residents.)
- When health center personnel are following a patient in the hospital, the primary health center personnel in attendance during the visit is the provider who receives credit for the visit, even if other personnel are present.
- Except for physicians and dentists, allocate personnel by function among the major service categories based on time dedicated to each position.
- Report physicians according to the specialty in which they are board certified. If a physician has multiple board certifications, report each physician under the specialty in which they are functioning. FTE and visits for physicians with multiple board certifications should be allocated according to the specialty they are practicing.
- Appendix A provides a listing of personnel. Only personnel designated as a "provider" can generate countable visits for purposes of UDS reporting.
- Table 5 provides further clarifications to these definitions. See Instructions for Table 5: Staffing and Utilization.
- Providers may be employees of the health center, contracted personnel, or volunteers.
- Contracted providers who are paid for their time by the health center with grant funds or program income and who are part of the scope of project, serve center patients, and document their services in the health center's records count as providers, and their FTE is reported.
- Contracted providers who are paid for specific visits or services with grant funds or program income and report patient visits to the direct recipient of a HRSA's BPHC or BHW grant or designation (e.g., under a migrant voucher program or for HCH awardees with sub-awardees) are providers. The direct recipient of the HRSA's BPHC or BHW grant or designation reports these providers' activities. Since such providers often have no time basis in their report, no FTE would be reported for them if time data were not separately collected.
- Providers who volunteer to serve patients at the health center's service delivery sites under the supervision of the health center's personnel and document their services and time in the center's records are counted and their FTE is reported.
- Individuals or groups who provide services under formal agreement or contract when the health center DOES NOT pay for the visit are not credited as providing a health center visit, unless they are working at an approved service delivery site under the supervision of the appropriate health center personnel and are credentialed by the health center. These providers are generally providing services noted in Column III of the grant scope of project application Form 5A.

FAQ FOR THE INSTRUCTIONS FOR TABLES

1. **What level of documentation is required for emergency, hospital, or respite services? Can we count the visit if the record is incomplete?**

   A patient receiving documented emergency services counts even if some portions of the patient health record are incomplete. Providers who see their established patients at a hospital or respite care facility and make a note in the institutional file can satisfy this criterion by including a summary discharge or interim note showing activities for each of the visit dates.

2. **Do we credit a visit to the nurse assisting a physician?**

   No. For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history, or drawing a blood sample does not receive credit as a separate visit. Countable medical visits usually involve one of the "Evaluation and Management" billing codes (99202–99205 or 99211–99215) or one of the health maintenance codes (99381–99387, 99391–99397).

3. **Two different medical providers treated the patient at the health center on the same day. Can we count both?**

   No. Only count one visit per service category when care is provided at the same location. For example, only count one medical visit if an obstetrician/gynecologist (OB/GYN) provides prenatal care to a patient at the health center and a nurse practitioner treats that same patient's hypertension at the same location on the same day. Other examples may include: a family physician and a pediatrician who both see a child or a dental hygienist and a dentist who both see a patient on the same day.

Instructions for Patients by ZIP Code Table

The Patients by ZIP Code Table collects data on patients' geographic residence by ZIP code[8] and by primary medical insurance.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.

UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[9] websites.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

PATIENTS BY ZIP CODE

- All health centers must report the number of patients served by ZIP code and medical insurance.
- This information enables HRSA's BPHC to better identify areas served by health centers, service area overlaps, and possible areas of unmet need.
- Patients may be mobile during the calendar year; report patients' most recent ZIP code on file.
- ZIP code information for each patient is to be updated each calendar year.

ZIP Code of Specific Groups

For health centers serving patients without residence information, such as individuals from transient groups, follow the instructions below:

[8] The geographic residence of patients served during the calendar year largely comprises the health center service area and should generally align with the ZIP codes recorded in the health center scope of project.
[9] Login credentials are required. Users may request access through the Health Center Program Community.

Patients experiencing homelessness	• Report the service location ZIP code as a proxy when a ZIP code location is unavailable. If the patient is staying at a shelter or otherwise has an address, use the ZIP code of that location. • If the patient receives services in a mobile health center van and has no other ZIP code, report the ZIP code of the van's location on the day of that visit. • If the patient is living in permanent supportive housing or doubled up, report that location as the ZIP code. • Although it is appropriate from a clinical and service delivery perspective to collect the address of a contact person to facilitate communication with the patient; DO NOT use the contact person's address as the patient's address.
Patients who are migratory agricultural workers	• Report the ZIP code of where the patient lived *when* they received care from the health center. Migratory agricultural workers (as opposed to seasonal workers) may have both a temporary address, where they live when working, and a permanent or "downstream" address. • Report the ZIP code for the location (fixed service delivery site or mobile camp) where patients received services, for those whose ZIP code is unavailable (e.g., living in cars or on the land).
Patients who are foreign nationals	• Report the current ZIP codes for people from other countries who reside in the United States either permanently or temporarily. • Report "Other ZIP Code" in cases where patients have a permanent residence outside the country, if they have no temporary address in the United States.

Unknown ZIP Code

Report residence in the "Unknown" category for patients whose residence is not known or for whom a proxy ZIP code is not available.

Ten or Fewer Patients in ZIP Code

To ease the burden of reporting, combine and report patients from ZIP codes that have **10 or fewer** patients in the "Other ZIP Codes" category.

INSTRUCTIONS FOR PATIENTS BY MEDICAL INSURANCE

- Report the patient's **primary medical insurance covering medical care, if any, as of their last visit during the calendar year**.
- Report **primary medical insurance** for all patients, regardless of the services they receive. This applies to patients who did not receive medical care, such as dental-only or behavioral health-only patients, as well as patients whose medical insurance did not cover the service.
- Report patients' ZIP code by their primary medical insurance.
- DO NOT report children as Uninsured unless they are receiving minor consent services or their family is uninsured.
- DO NOT report patients as Uninsured simply because they are receiving a service that is not covered by health insurance.

Insurance Categories

Primary medical insurance is the insurance plan that the health center would typically bill first for medical services, even if that insurance pays for none or only a portion of the visit. Specific rules guide reporting:

- The categories for this table are slightly different from those on Table 4; they combine Medicaid, Children's Health Insurance Program (CHIP), and Other Public into one category.
- Report patients who have both Medicare and Medicaid (dually eligible) as Medicare patients, because Medicare is billed before Medicaid. The exception to the Medicare-first rule is the Medicare-enrolled patient who is still working and insured by both an employer-based plan and Medicare. In this case, the primary health insurance is the employer-based plan, which is billed first.
- Report Medicare administered by a private insurance company as Medicare.
- Report Medicaid and CHIP patients enrolled in a managed care plan administered by a private insurance company as Medicaid/CHIP/Other Public.
- Report the patient by their medical insurance, even if for some reason the health center does not bill the specified insurance.
- Report only third-party insurance that patients carry. Section 330 grant awards used to serve special populations (e.g., MHC, HCH, PHPC) are NOT a form of medical insurance.
- Report patients who are incarcerated as Uninsured (whether they were seen in the correctional facility or at the health center), unless Medicaid or other insurance covers them, and at the ZIP code of the jail or prison.
- In instances where patients are in residential drug programs, college dorms, military barracks, etc., report the patient as living at the ZIP code of the residential program, dorm, or barrack and by their primary medical insurance, NOT as Uninsured.
- Report patients whose care is paid for by state or local government indigent care programs as Uninsured.
- Report patients who received insurance through the Health Insurance Marketplace as Private.
- Affordable Care Act subsidies (i.e., cost-sharing premium reductions and premium tax credits) DO NOT affect insurance categories. Classify patients by their third-party insurer.

FAQ FOR PATIENTS BY ZIP CODE TABLE

1. **Do we need to collect information and report on the ZIP code of all our patients?**

   Yes. Although health centers report residence by ZIP code for all patients, some centers may draw patients from multiple ZIP codes outside of their normal service area. To ease the burden of reporting, consolidate ZIP codes with 10 or fewer patients in the "Other" category.

2. **Do we need to collect information and report on the primary medical insurance of all our patients?**

   Yes. Although the ZIP code of a patient may be Unknown, medical insurance information *must* be obtained for every individual counted as a patient.

3. **If a patient did not receive medical care, do we still need their medical insurance information? What about dental patients?**

   Yes. This information is about patients' primary medical insurance resources, not billing. Obtain medical insurance information for **all** patients, even dental-only patients. For example, if a patient received only mental health services, still determine whether they have primary medical insurance and report it.

4. **How do we report patients by insurance when we DO NOT bill that form of insurance?**

   All patients must be asked for their primary medical insurance, generally through the patient registration process, although it may be explained to them that this is required for planning purposes and that their insurance will not be billed. Report the patient by their primary medical insurance, even in those instances that the health center does not or cannot bill to that insurance. Include, for example, patients enrolled in managed care Medicaid but assigned to another primary care provider, or patients with private insurance for which the health center's providers have not been credentialed.

5. **How do we report patients by insurance who have their care subsidized by an indigent care program?**

   Report patients as Uninsured when their care is subsidized by a state or local government indigent care program. Examples include New Jersey's Uncompensated Care Program, New York's Public Goods Pool Funding, and Colorado's Indigent Care Program.

6. **We see children at local schools. Do we include the patients seen in the report?**

   Report children served in school-based service sites only if they have completed clinic intake forms that show insurance status and family/household income and the patient had a countable visit.

7. **Does the number of patients reported by ZIP code need to equal the total number of unduplicated patients reported on Tables 3A, 3B, and 4?**

   Yes. Several tables and sections must match:

   - The total number of patients reported by ZIP code (including Unknown and Other) on the Patients by ZIP Code Table must equal the number of total unduplicated patients reported on Table 3A and the race and ethnicity section totals of Table 3B and the income and insurance section totals of Table 4.

   - The insurance totals reported on the Patients by ZIP Code Table must equal insurance reported on Table 4. Specifically:

     - The total for Patients by ZIP Code Table Column B (Uninsured) must equal Table 4, Line 7, Columns A + B.

     - The total for Patients by ZIP Code Table Column C (Medicaid/CHIP/Other Public) must equal the sum of Table 4, Line 8, Columns A + B and Line 10, Columns A + B.

     - The total for Patients by ZIP Code Table Column D (Medicare) must equal Table 4, Line 9, Columns A + B.

     - The total for Patients by ZIP Code Table Column E (Private) must equal Table 4, Line 11, Columns A + B.

PATIENTS BY ZIP CODE TABLE

Calendar Year: January 1, 2024, through December 31, 2024

ZIP Code (a)	None/ Uninsured (b)	Medicaid/ CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes					
Unknown Residence					
Total					

Note: The actual output from the EHBs will display ZIP codes entered by the health center in Column A.

Patients by ZIP Code Table Cross-Table Considerations:

- Patients by ZIP Code Table and Tables 3A, 3B, and 4 describe the same patients and the totals must be equal.
- The number of patients by insurance source reported on the Patients by ZIP Code Table must be consistent with the number of patients by insurance category reported on Table 4.

Instructions for Tables 3A and 3B

Tables 3A and 3B collect demographic data (age, sex, race, ethnicity, and language) for patients who accessed services during the calendar year. This information must be collected from patients initially as part of the patient registration or intake process and updated or confirmed annually thereafter.

TABLE 3A: PATIENTS BY AGE AND BY SEX - INSTRUCTIONS

Table 3A provides an unduplicated count of each patient's age and sex.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.

UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[10] websites. This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

- Report the number of patients by appropriate categories for age and sex.
- Use the individual's **age on December 31, 2024**.
- Report the date of birth and sex listed on the birth certificate for all patients. There is no "Unknown" or "Other" category on this table.

Note: On the non-prenatal portions of Tables 6B and 7, age is defined differently by measure. Thus, the numbers on Table 3A may not be the same as those on Tables 6B and 7 (though they will usually be similar).

[10] Login credentials are required. Users may request access through the Health Center Program Community.

TABLE 3B: DEMOGRAPHIC CHARACTERISTICS - INSTRUCTIONS

Table 3B provides an unduplicated count of patients by demographic characteristics.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting: In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.

UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[11] websites. This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

Report the number of patients by their self-identified race, ethnicity, and language preference.

PATIENTS BY HISPANIC, LATINO/A, OR SPANISH ETHNICITY AND RACE (LINES 1–8)

Table 3B displays the race and ethnicity of the patient population in a matrix format. This allows for reporting on the racial and ethnic identification of all patients.

Hispanic, Latino/a, or Spanish Ethnicity

Table 3B collects information on whether or not patients consider themselves to be of Hispanic, Latino/a, or Spanish ethnicity, regardless of their race.

[11] Login credentials are required. Users may request access through the Health Center Program Community.

Columns A1–A5 (Hispanic, Latino/a, or Spanish Origin)	Column B (Not Hispanic, Latino/a, or Spanish Origin)	Column C (Unreported/Chose Not to Disclose Ethnicity)
• Report the number of patients of Mexican, including Mexican American and Chicano/a (Column a1), Puerto Rican (Column a2), Cuban (Column a3), another Spanish culture or origin (Column a4), or Hispanic, Latino/a, or Spanish origin combined (Column a5), broken out by their racial identification. Include in this count Hispanic, Latino/a, or Spanish origin patients born in the United States. • Report patients who are of Hispanic, Latino/a, or Spanish origin but for whom granularity of ethnicity is not known, as well as patients who select more than one ethnicity, in Column a5 (e.g., Mexican and Puerto Rican). • Report patients who self-report as being of Hispanic, Latino/a, or Spanish ethnicity but DO NOT separately select a race on Line 7, as "Unreported/Chose not to disclose race." Health centers should not default these patients to any other category. • DO NOT include patients from Portugal, Brazil, or Haiti whose ethnicity is not otherwise tied to the Spanish language.	• Report the number of patients who indicate that they are NOT of Hispanic, Latino/a, or Spanish origin. • If a patient self-reported a race but has not made a selection for the Hispanic/Not Hispanic, Latino/a, or Spanish origin question, presume that the patient is NOT of Hispanic, Latino/a, or Spanish origin.	• Report on Line 7 only those patients who left the entire race and Hispanic, Latino/a, or Spanish ethnicity part of the intake form blank or those who indicated that they choose not to disclose these data. Only one cell is available in this column. **Note:** Column C is grayed out on all race lines except for the "Unreported/Chose not to disclose race" line.

Race

All patients must be classified in one of the racial categories.

- Report patients in one of 16 race categories:
  - Line 1, Asian, as Asian Indian (Line 1a), Chinese (Line 1b), Filipino (Line 1c), Japanese (Line 1d), Korean (Line 1e), Vietnamese (Line 1f), or Other Asian (Line 1g)
  - Line 2, Native Hawaiian/Other Pacific Islander, as Native Hawaiian (Line 2a), Other Pacific Islander (Line 2b), Guamanian or Chamorro (Line 2c), or Samoan (Line 2d)
  - Line 3, Black or African American
  - Line 4, American Indian/Alaska Native
  - Line 5, White
  - Line 6, More than one race
  - Line 7, Unreported/Chose not to disclose race
- Patients categorized as "Asian/Asian American/Pacific Islander" in other systems are reported on the UDS in one of five distinct categories:
  - **Line 1, Asian:** Patients having ancestry in any of the original peoples of Asia, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, or Vietnam.
    - Include in the Other Asian category patients who are Asian, but for whom the granularity of their race is not known, as well as patients who select more than one of the Asian subcategories listed (e.g., Chinese and Filipino).
  - **Line 2a, Native Hawaiian:** Patients having ancestry in any of the original peoples of Hawai'i.
  - **Line 2b, Other Pacific Islander:** Patients having ancestry in any of the original peoples of Tonga, Palau, Chuuk, Yap, Kosrae, Ebeye, Pohnpei, or other Pacific Islands in Melanesia or Oceana. Include in the Other Pacific Islander category patients who are of other Pacific islands, but for whom the granularity of their race is not known.
  - **Line 2c, Guamanian or Chamorro:** Patients having ancestry in any of the original peoples of the Northern Mariana Islands, Guam, Saipan, Tinian, Rota, or other Mariana Islands in Micronesia.
  - **Line 2d, Samoan:** Patients having ancestry in any of the original peoples of the Samoan Islands, Savai'i, Manono, Upolu, Tutuila, Pola Island, Aunu'u, or other Samoan Islands in American Samoa or Polynesia.
    - Include in the Other Pacific Islander category patients who are Other Pacific Islander but for whom the granularity of their race is not known, as well as patients who select more than one of the Other Pacific Islander subcategories (e.g., Guamanian and Samoan).
- Report patients who trace their ancestry to any of the original peoples of North, South, and Central America and who maintain tribal affiliation or community attachment on Line 4, American Indian/Alaska Native.
- Report patients who trace their ancestry to any of the original peoples of Europe, the Middle East, or North Africa on Line 5, White.
- **Line 6, More than one race:** Use this line only if your system captures multiple races and the patient has chosen two or more races (but not a race and an ethnicity). This is usually done with an intake form that lists the races and tells the patient to "check one or more" or "check all that apply." "More than one race" must NOT appear as a selection option on your intake form.

  - Report patients who select multiple races within the Asian or Native Hawaiian/Other Pacific Islander race categories on the "other" race line for that category. DO NOT report these patients on Line 6, More than one race.
    - Report patients who select multiple Asian races (Lines 1a–1f) as Other Asian (Line 1g).
    - Report patients who select multiple Native Hawaiian/Other Pacific Islander races (Lines 2a–2c) as Other Pacific Islander (Line 2d).
  - DO NOT use "More than one race" for Hispanic, Latino/a, or Spanish people who DO NOT select a race. Report these patients on Line 7 (Unreported/Chose not to disclose), as noted above.
- Report patients who did not provide their race, including when information was sought but not found or asked but unknown, on Line 7, Unreported/Chose not to disclose race.
- Report patients who self-report their race but DO NOT indicate if they are Hispanic, Latino/a, or Spanish origin in Column B as not of Hispanic, Latino/a, or Spanish origin on the appropriate race line.

PATIENTS BEST SERVED IN A LANGUAGE OTHER THAN ENGLISH (LINE 12)

This section of Table 3B identifies the patients who may have linguistic barriers to care.

- Report on Line 12 the number of patients who are best served in a language other than English, including those who are best served in sign language.
- Include those patients who were served in a second language by a bilingual provider, a third-party interpreter, and those who may have brought their own interpreter.
- Include patients who are best served in a language other than English, even in areas where a language other than English is the dominant language, such as Puerto Rico or the Pacific Islands.

FAQ FOR TABLES 3A AND 3B

1. **Our health center collects different race and ethnicity data than required by the UDS. Why are the data collected at this level?**

   The UDS classifications are consistent with those used by the Census Bureau and HHS as per the October 2011 guidance titled "U.S. Department of Health and Human Services Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status" issued by OMB. These standards govern the categories used to collect and present federal data on race and ethnicity. OMB requires a minimum of five categories (White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander) for race. HHS data standards, used for the reporting of race and ethnicity for Table 3B, are based on the disaggregation of the OMB standard.

2. **Do we have to report the race and ethnicity of all our patients?**

   Yes. Health centers whose data systems DO NOT support such reporting must enhance their systems to permit the required level of reporting, rather than using the "Unreported/Chose not to disclose" categories. If a patient self-identifies as of Hispanic, Latino/a, or Spanish origin with no distinction within the sub-categories listed (Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, another Spanish origin), report the patient in Column a5. Also report patients who report more than one ethnicity (e.g., Hispanic and other Spanish origin) in Column a5.

3. **How are patients of Hispanic, Latino/a, or Spanish ethnicity reported?**

Race and ethnicity data appear in a matrix on Table 3B. Patients who in other systems might be reported as Hispanic or Latino/a independent of race are reported in Column A (in one of the detail columns, a1–a4) of Table 3B of the UDS as of Hispanic, Latino/a, or Spanish origin and reported on Lines 1–7 based on their race. If Hispanic, Latino/a, or Spanish ethnicity is the only identification recorded in the center's patient files, report these patients in Column A on Line 7 as having an "unreported" racial identification, and update your data system to permit the collection of both race and ethnicity for future reporting.

4. Can we have a choice on our registration form of "more than one race"?

No. To count patients as being of "more than one race," they must have the option of checking two or more boxes under race and must have indeed checked more than one. Do not include "more than one race" as an option on registration forms.

5. How are patients who receive different types of services or use more than one of our health center's service delivery sites reported? For example, how do we report a patient who receives both medical and dental services or a patient who receives primary care from one service delivery site but gets prenatal care at another?

The Patients by ZIP Code Table and Tables 3A, 3B, and 4 each provide an unduplicated patient count. Count each individual who has at least one visit reported on Table 5 only once on the Patients by ZIP Code Table and Tables 3A, 3B, and 4, regardless of the type or number of services they receive or where they receive them. We define visits in detail in the Instructions for Tables that Report Visits, Patients, and Providers section. Note the following:

DO NOT count individuals who:

- receive WIC services and no other services at the health center as patients on Table 3A or 3B (or anywhere in the UDS).
- only receive imaging or lab services or whose only service was an immunization or screening test as patients on Table 3A or 3B (or anywhere in the UDS).
- only receive health status checks and health screenings as patients on Table 3A or 3B (or anywhere in the UDS).

6. Do we exclude from the UDS Report a patient who died during the year?

No. If a patient was seen during the calendar year prior to their death, include the patient and their visits in all applicable areas of the UDS Report, including their demographics, services, and clinical care details.

7. Should the totals on Tables 3A and 3B be equal to UDS totals reported on other tables or sections?

Yes.

The sum of Table 3A, Line 39, Columns A and B (total patients by age and by sex) must equal:

- Patients by ZIP Code Table total;
- Table 3B, Line 8, Column D (total patients by Hispanic, Latino/a, or Spanish ethnicity and race);
- Table 4, Line 6 (total patients by income); and
- Table 4, Line 12, Columns A and B (total patients by insurance status).

The sum of Table 3A, Lines 1–18, Columns A and B (total patients age 0–17 years) must equal:

- Table 4, Line 12, Column A (total patients age 0–17 years).

The sum of Table 3A, Lines 19–38, Columns A and B (total patients age 18 and older) must equal:

- Table 4, Line 12, Column B (total patients age 18 and older).

8. I have multiple, separate data systems. How do I include their data on these tables?

It is the health center's responsibility to ensure there is no duplication of data. Count patients only once, regardless of the number of different types of services they receive. This may require the downloading and merging of data from each system to eliminate duplicates or checking them manually. This can be a time-consuming and potentially expensive process and should start as soon as the year ends to ensure sufficient time for completion prior to the submission due date.

TABLE 3A: PATIENTS BY AGE AND BY SEX

Calendar Year: January 1, 2024, through December 31, 2024

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum of Lines 1–38)		

Table 3A Cross-Table Considerations:

- Table 3A, Line 39 = Table 3B, Line 8, Column D = total patients on the Patients by ZIP Code Table = Table 4, Lines 6 and 12.
- If you submit Grant Reports, the total number of patients reported on each grant table must be less than or equal to the corresponding number on the Universal Report for each cell.

TABLE 3B: DEMOGRAPHIC CHARACTERISTICS

Calendar Year: January 1, 2024, through December 31, 2024

	Patients by Race and Hispanic, Latino/a, or Spanish Ethnicity									
Line	**Patients by Race**	**Yes, Mexican, Mexican American, Chicano/a (a1)**	**Yes, Puerto Rican (a2)**	**Yes, Cuban (a3)**	**Yes, Another Hispanic, Latino/a, or Spanish Origin (a4)**	**Yes, Hispanic, Latino/a, Spanish Origin, Combined (a5)**	**Total Hispanic, Latino/a, or Spanish Origin (a) (Sum Columns a1 + a2 + a3 + a4 + a5)**	**Not Hispanic, Latino/a, or Spanish Origin (b)**	**Unreported / Chose Not to Disclose Ethnicity (c)**	**Total (d) (Sum Columns a+b+c)**
1a	Asian Indian								<cell not reported>	
1b	Chinese								<cell not reported>	
1c	Filipino								<cell not reported>	
1d	Japanese								<cell not reported>	
1e	Korean								<cell not reported>	
1f	Vietnamese								<cell not reported>	
1g	Other Asian								<cell not reported>	
1	Total Asian (Sum Lines 1a+1b+1c+1d+1e+1f+1g)								<cell not reported>	
2a	Native Hawaiian								<cell not reported>	
2b	Other Pacific Islander								<cell not reported>	
2c	Guamanian or Chamorro								<cell not reported>	
2d	Samoan								<cell not reported>	
2	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a+2b+2c+2d)								<cell not reported>	
3	Black or African American								<cell not reported>	
4	American Indian/Alaska Native								<cell not reported>	
5	White								<cell not reported>	
6	More than one race								<cell not reported>	
7	Unreported/Chose not to disclose race									
8	**Total Patients** (Sum of Lines 1 + 2 + 3 to 7)									

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	

Table 3B Cross-Table Considerations:

- Table 3B, Line 8 = Table 3A, Line 39 = Patients by ZIP Code Table = Table 4, Lines 6 and 12.
- Tables 3B and 7 both report patients by race and Hispanic, Latino/a, or Spanish ethnicity. The data sources for identifying race and ethnicity for the two tables should be the same, and the number of patients reported on Table 7 by race and ethnicity cannot exceed the number of patients in the same category on Table 3B.
- If you submit Grant Reports, the total number of patients reported on each grant table must be less than or equal to the corresponding number on the Universal Report for each cell.

Instructions for Table 4: Selected Patient Characteristics

Table 4 collects descriptive data on selected characteristics of health center patients.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.
UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[12] websites.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

INCOME AS A PERCENTAGE OF POVERTY GUIDELINE, LINES 1–6

The report should include the most current income data for **all** patients (not only from patients eligible for a sliding fee discount), which must have been collected at or within 12 months of the last calendar year visit.

Determine a patient's income relative to the 2024 federal poverty guidelines (FPG).

- Report patients by income, as defined by the health center's board policy consistent with the Health Center Program Compliance Manual. Children, with the exception of emancipated minors or those presenting for minor consent services, should be classified under their parents' or guardians' income.
- Report patients whose information was not collected at or within 12 months of their last visit in the calendar year on Line 5 as "Unknown."
- Self-declaration of income from patients is acceptable as long as that is consistent with the health center's board-approved policies and procedures for collecting these data. This option is particularly important for those patients whose wages are paid in cash and who have no other means of proving their income. If income information consistent with the health center's board policy is lacking, report the patient as having "Unknown" income.
- DO NOT allocate patients with "Unknown" income to the other income groups.
- DO NOT classify a patient who is experiencing homelessness, is a migratory agricultural worker, or is on Medicaid as having income below the FPG based on these factors alone.

PRIMARY THIRD-PARTY MEDICAL INSURANCE, LINES 7–12

This portion of the table provides data on patients classified by their age and primary source of insurance for **medical** care. Health centers are required to collect medical insurance information each calendar year from **all** patients to maximize third-party payments. Note that there is **NO** "Unknown" insurance classification on this table. DO NOT report other forms of insurance, such as dental, mental health, or vision coverage. Also note that states often rename federal insurance programs, such as CHIP and Medicaid.

- Report the primary **medical** insurance patients had at the time of their last visit, regardless of whether that insurance was billed or paid for any or all of the visit services.

[12] Login credentials are required. Users may request access through the Health Center Program Community.

Note: If a patient's medical insurance is not known but they have Medicaid, Private, or Other Public dental insurance at the time of their last visit, you **may** assume they have the same kind of medical insurance. If they DO NOT have dental insurance at the time of their last visit, you **may NOT** assume they are Uninsured for **medical care**. You must determine whether they have medical insurance.

- Patient primary medical insurance is classified into seven types, as shown on the following pages.
- In rare instances, a patient may have insurance that the health center cannot or does not bill. Even in these instances, report the patient as being insured and report the type of insurance.
- Patients are divided into two age groups: 0–17 (Column A) and 18 and older (Column B) based on their age on December 31, 2024 (consistent with ages reported on Table 3A).
- DO NOT report public programs that reimburse for selected services, such as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; Breast and Cervical Cancer Early Detection Program (BCCEDP); or Title X, as a patient's primary medical insurance.

Note: Report the revenue from public programs that reimburse for selected services as Other Public payers on Table 9D.

None/Uninsured (Line 7)

Report patients who did NOT have medical insurance at the time of their last visit on Line 7. This may include patients who were insured earlier in the year and patients whose visit was paid for by a third-party source that was not insurance, such as EPSDT, BCCEDP, Title X, or some state or local safety net or indigent care programs. Some considerations:

- Report a minor receiving services with parental consent under the family's insurance.
- Report children seen in a school-based service site under their parent's health insurance. This information must be obtained if they are to be included in the UDS Report. Report emancipated minors or patients seeking minor consent services permitted in the state, such as family planning or mental health services, as Uninsured if they DO NOT have access to the parent's information.
- Presume a patient with Medicaid, Private, or Other Public dental insurance to have the same kind of medical insurance. If a dental patient **does not** have dental insurance, you may NOT assume that they are uninsured for medical care. Instead, obtain this information from the patient.
- Patients served in correctional facilities may be classified as Uninsured unless there is documentation of insurance, such as Medicaid or Medicare, in which case report them on that insurance line.
- Obtain the coverage information of patients in facilities (other than correctional), such as residential drug programs, college dorms, and military barracks. DO NOT assume them to be uninsured.
- DO NOT report patients as Uninsured if they have medical insurance that did not pay for their visit.

Medicaid (Line 8a)

Report patients covered by state-run programs operating under the guidelines of Titles XIX and XXI (as appropriate) of the Social Security Act.

- Include Medicaid programs known by state-specific names (e.g., California's "Medi-Cal" program).
- Include patients covered by "state-only" programs covering individuals who are ineligible for federal matching funds (e.g., pregnant women) and paid through Medicaid, if they cannot otherwise be identified as having another insurance.

- Report patients enrolled in both Medicaid and Medicare on Lines 9 (Medicare) **and** 9a (Dually Eligible), but not on Line 8a (Medicaid).
- Report patients who are enrolled in Medicaid but receive services through a private managed care plan that contracts with the state Medicaid agency on Line 8a, not as privately insured (Line 11). This also applies in states that have a Medicaid waiver permitting Medicaid funds to be used to purchase private insurance for services.

CHIP Medicaid (Line 8b)

Report patients covered by the Children's Health Insurance Program (CHIP) Reauthorization Act and provided through the state's Medicaid program.

- In states that use Medicaid to handle the CHIP program, it is sometimes difficult or impossible to distinguish between "Medicaid" and "CHIP Medicaid." In other states, the distinction is readily apparent (e.g., they have different cards). Even where it is not obvious, CHIP patients may still be identifiable from a "plan" code or some other embedded code in the membership number. This may also vary from county to county within a state. Obtain information on coding practice from the state and/or county.
- If there is no way to distinguish between Medicaid and CHIP administered through Medicaid, classify all covered patients as Medicaid (Line 8a).

Medicare (Line 9)

Report patients covered by the federal insurance program for the aged, blind, and disabled (Title XVIII of the Social Security Act).

- Report patients who have Medicare and Medicaid ("dually eligible") on Line 9. **In addition**, report as Dually Eligible on Line 9a.
- Report patients who have Medicare and a private ("Medigap") insurance on Line 9. DO NOT include them as Dually Eligible on Line 9a.
- Report patients enrolled in "Medicare Advantage" products on Line 9, even though their services were covered by a private insurance company.
- Report Medicare-enrolled patients who are still working and are insured by both an employer-based plan and Medicare as Private Insurance on Line 11, because the employer-based insurance plan is billed first. DO NOT include them as Dually Eligible on Line 9a.

Dually Eligible (Medicare and Medicaid) (Line 9a)

Report patients with both Medicare and Medicaid insurance.

- Report patients who are dually eligible and enrolled in both Medicare and Medicaid on Line 9a **and** include them on Line 9. This line is a subset of Line 9 (Medicare).
- Report patients who are enrolled in Medicare Advantage Special Needs Plan as Dually Eligible on Line 9a.
- DO NOT include Medicare gap "Medigap" (supplemental insurance plan) enrollees on Line 9a. Report patients who buy Medicare gap insurance as Medicare patients, on Line 9.

Other Public Insurance (Non-CHIP) (Line 10a)

Report state and/or local government programs that provide a broad set of benefits for eligible individuals. Include any public-paid or subsidized private insurance not reported elsewhere on Table 4.

- Report Medicaid expansion programs (such as state premium assistance programs) using Medicaid funds to help patients purchase their insurance through exchanges as Medicaid (Line 8a) if it is possible to identify them. Otherwise, report them as Private Insurance (Line 11).
- DO NOT report any CHIP, Medicaid, or Medicare patients on Line 10a.
- DO NOT report uninsured individuals whose visit may be covered by a public source with limited benefits, such as Title X, EPSDT, BCCEDP, AIDS Drug Assistance Program providing pharmaceutical coverage for patients with human immunodeficiency virus (HIV), etc.

  Note: Public programs that reimburse for selected services are, however, considered Other Public payers on Table 9D.
- DO NOT include patients covered by workers' compensation (which is liability insurance for the employer—not health insurance for the patient).
- DO NOT include patients who have insurance through federal or state insurance exchanges, regardless of the extent to which their premium cost is subsidized (in whole or in part). Report them as Private Insurance (Line 11).

Other Public Insurance CHIP (Line 10b)

Report patients on the Other Public Insurance CHIP line in states where CHIP is contracted through a private third-party payer.

- Report CHIP programs that are run through the private sector, often administered through health maintenance organizations (HMOs). Coverage may appear to be a private insurance plan (such as Blue Cross/Blue Shield) but is funded through CHIP and is to be counted on Line 10b.
- Report CHIP patients who are on plans administered by Medicaid coordinated care organizations (CCOs).
- DO NOT report CHIP as Private Insurance.

Private Insurance (Line 11)

Report patients with health insurance provided by private (commercial) and not-for-profit companies.

- Individuals may obtain insurance through employers or on their own.
- Include patients who purchase insurance through the federal or state exchanges.
- In states using Medicaid expansion to support the purchase of insurance through exchanges, report patients covered under these plans on Line 8a (Medicaid). Report patients who are not identifiable as Medicaid patients on Line 11 (Private Insurance).
- Private insurance includes insurance purchased for public employees or retirees, such as Tricare, Trigon, or the Federal Employees Benefits Program.

MANAGED CARE UTILIZATION, LINES 13A–13C

This part of Table 4 provides data on managed care enrollment during the calendar year and specifically reports on patient member months in health center contracted comprehensive medical managed care plans.

- If patients are enrolled in a managed care plan that permits them to receive care from any number of providers, including providers other than the health center and its providers, this is NOT to be reported as managed care in the UDS, and NO member months are reported.
- DO NOT report in this section enrollees in primary care case management (PCCM) programs, the Centers for Medicare & Medicaid Services (CMS) patient-centered medical home (PCMH) demonstration grants, or other third-party plans that pay a monthly fee (often as low as $5 to $10 per member per month) to manage patient care, unless they are also enrolled in a comprehensive medical managed care plan.
- DO NOT include managed care enrollees whose capitation or enrollment is limited to behavioral health or dental services only. (However, an enrollee who has medical and dental is counted.)

Note: The determination of managed care reporting in the UDS is that the health center has a contractual agreement with a managed care organization or managed care plan through which the health center is assigned patients and is responsible for managing the comprehensive care of those patients.

Member Months

A member month is defined as one individual enrolled in a managed care plan for one month. For example, an individual who is a member of a plan for a full year generates 12 member months; a family of five enrolled for 6 months generates 30 member months (5 individuals × 6 months = 30 member months).

Member month information is most often obtained from monthly enrollment lists generally supplied by managed care companies to their providers. Health centers should always save the information contained within these documents. In the event they have not been saved, health centers should request duplicates early to permit timely filing of the UDS Report.

Note: It is possible for an individual to be enrolled in a managed care plan, assigned to a health center, and yet not seen during the calendar year. The member months for such individuals are still to be reported in this section. **This is the only place on the UDS tables that may report an individual who is not being counted as a patient.**

Capitated Member Months (Line 13a)

Report the total capitated member months by source of payment. This is derived by adding the total enrollment reported from each capitated plan for each month.

- A patient is in a capitated plan if the contract between the health center and the HMO, accountable care organization (ACO), or other similar plan stipulates that, for a flat payment per month, the health center will provide the patient all the services on a negotiated list. (Oregon plans should include enrollees in CCOs on this line.)
- This usually includes, at a minimum, all medical office visits.
- Payments are received (and reported on Table 9D) regardless of whether any service is rendered to the patient in that month. The capitated member months reported on Line 13a relate to the net capitated revenue reported on Table 9D, Lines 2a, 5a, 8a, and/or 11a.

Fee-for-Service Member Months (Line 13b)

Report the total fee-for-service member months by source of payment.

- A fee-for-service member month is defined as one patient being assigned to a health center or health center service delivery provider for one month, during which time the patient may receive contractually defined

basic primary care services only from the health center but for whom the services are paid on a fee-for-service basis.

- There is a relationship between the fee-for-service member months reported on Line 13b and the revenue reported on Table 9D on Lines 2b, 5b, 8b, and/or 11b.
- It is common for patients to have their primary care covered by capitation but other services (e.g., behavioral health or pharmacy) paid separately on a fee-for-service basis as a "carve-out" in addition to the capitation. DO NOT include member months for individuals who receive "carved-out" services under a fee-for-service arrangement on Line 13b if those individuals have already been counted for the same month as a capitated member on Line 13a.

SPECIAL POPULATIONS, LINES 14–26

This section asks for a count of patients from special populations, including migratory and seasonal agricultural workers and their family members, patients who are experiencing homelessness, patients who are served by school-based service sites, patients who are veterans, and patients who are served at a health center located in or immediately accessible to a public housing site. Awardees who receive funding from section 330(g) (MHC) and section 330(h) (HCH) must provide additional information on their agricultural employment and/or housing characteristics.

- All health centers report these populations, regardless of whether they directly receive special population funding.
- The special populations detailed below are not mutually exclusive. Patients can be reported in more than one category, as appropriate (e.g., a patient can be reported as both a veteran and experiencing homelessness).

Total Migratory and Seasonal Agricultural Workers and Their Family Members, Lines 14–16

Total Agricultural Workers or Their Family Members, Line 16: Report the number of patients seen during the calendar year who were either migratory or seasonal agricultural workers, family members of migratory or seasonal agricultural workers, or aged or disabled former migratory agricultural workers (as described in the statute section 330(g)(1)(B)). All health centers must report on this line, though for some the number may be zero.

Only health centers that receive section 330(g) (MHC) funding provide separate totals for migratory and seasonal agricultural workers on Lines 14 and 15. For section 330(g) awardees, the sum of Lines 14 + 15 = Line 16.

- For either migratory or seasonal agricultural workers, report patients who meet the definition of agriculture as farming in all its branches, as defined by the Office of Management and Budget (OMB)-developed North American Industry Classification System (NAICS), and include seasonal workers included in codes 111 and 112 and all sub-codes therein, including sub-codes 1151 and 1152.
- Migratory or seasonal agricultural workers' status must be verified at least every 2 years by MHC awardees.

Instructions for reporting migratory and seasonal agricultural workers:

- **Migratory Agricultural Workers, Line 14:** Report patients whose principal employment is in agriculture and who establish a temporary home for the purposes of such employment as a migratory agricultural worker, as defined by section 330(g) of the PHS Act. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who had such work as their principal employment within 24 months of their last visit during the calendar year, as well as their family members who have also used the center. The family members may or may not move with the worker or establish a temporary home.

Note: Agricultural workers who leave a community to work elsewhere are classified as migratory workers when served in their home community, as are those who migrate to a community to work there.

  - Include aged and disabled former migratory agricultural workers, as defined in section 330(g)(1)(B), and their family members. Aged and disabled former agricultural workers include those who were previously migratory agricultural workers but who no longer work in agriculture because of age or disability.

- **Seasonal Agricultural Workers, Line 15:** Report patients whose principal employment is in agriculture on a seasonal basis (e.g., picking fruit during the limited months of a picking season), but who DO NOT establish a temporary home for purposes of such employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. Include patients who have been so employed within 24 months of their last visit during the calendar year, as well as their family members who are patients of the health center.

  Note: Seasonal agricultural workers may be employed throughout the year for multiple crop seasons and as a result might work full-time.

Total Patients Experiencing Homelessness, Lines 17–23

Total Homeless, Line 23: Report the total number of patients known to have experienced homelessness at the **time of any service** provided during the calendar year, even if their housing situation changed during the year. Include patients on this line who experienced homelessness at any time during the year and were seen by the health center for services. All health centers must report on this line, though for some the number may be zero.

Only health centers receiving section 330(h) (HCH) funding provide separate totals for patients by housing location on Lines 17 through 22. For section 330(h) awardees, the sum of Lines 17 through 22 = Line 23.

- Report patients who lack housing. Include patients whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations. Include patients who reside in transitional housing or permanent supportive housing.
- Children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness may be included.[13]

Experiencing homelessness includes patients who at any point during the calendar year experienced homelessness or were at risk of homelessness for up to 12 months after they were last documented to experience homelessness. Housing status is based on the housing arrangement at the first visit during the calendar year when the patient is identified as experiencing homelessness.

HCH awardees will provide detail on patients experiencing homelessness by the type of shelter arrangement the patients had when they were **first encountered for a visit during the calendar year.** The following applies when categorizing patients for Lines 17 through 22:

- HCH awardees must collect housing status at the first visit of the year when the patient was identified to be experiencing homelessness. Further details are provided in the Total Patients Experiencing Homelessness, Lines 17–23 section.
- Report the patient's shelter arrangement as of the first visit during the calendar year **when the patient was identified as experiencing homelessnes**s. The shelter arrangement is reported as where the patient was housed the prior night.

[13] Health centers may use criteria as defined by the U.S. Department of Housing and Urban Development (HUD) to assist in defining "children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness."

- Report patients who spent the prior night incarcerated, in an institutional treatment program (e.g., mental health, substance use disorder), or in a hospital based on where they intend to spend the night **after** their visit/release. If they DO NOT know, report their shelter arrangement as Street, on Line 20.
- **Shelter, Line 17:** Report patients who are living in an organized shelter for individuals experiencing homelessness. Shelters that generally provide meals and a place to sleep are regarded as temporary and often limit the number of days or the hours of the day that a resident may stay at the shelter.
- **Transitional Housing, Line 18:** Transitional housing units are generally small units (six people is common) where people transition from a shelter and are provided extended, but temporary, housing stays (generally between 6 months and 2 years) in a service-rich environment. Transitional housing provides a greater level of independence than traditional shelters and may require the resident to pay some or all of the rent, participate in the maintenance of the facility, and/or cook their own meals. Report only those patients who are transitioning from a homeless environment. DO NOT include those who are transitioning from jail or those residing in or transitioning from an institutional treatment program, the military, schools, or other institutions.
- **Doubled Up, Line 19:** Report patients who are living with others. The arrangement is considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period. DO NOT include the individual who invites a patient experiencing homelessness to stay in their home for the night. DO NOT include a co-tenant rental as doubled up.
- **Street, Line 20:** Report in this category patients who are living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
- **Permanent Supportive Housing,**[14] **Line 21a:** Permanent supportive housing usually is in service-rich environments, does not have time limits, and may be restricted to people with some type of disabling condition.
- **Other, Line 21:** Report patients who were housed when first seen during the year and were no longer homeless, but who were **still eligible for the program because they experienced homelessness during the previous 12 months**. Under section 330(h), a health center may continue to provide services for up to 12 months after last documentation as experiencing homelessness to patients whom the health center has previously served but are no longer experiencing homelessness as a result of becoming a resident in permanent housing. Include them in this category. Also include patients who reside in single-room-occupancy (SRO) hotels or motels and patients who reside in other day-to-day paid housing or other housing programs that are intended for people experiencing homelessness.
- **Unknown, Line 22:** Report patients known to be experiencing homelessness whose housing arrangements are unknown.
- DO NOT report patients currently residing in a jail or an institutional treatment program as homeless until they are released to the street with no housing arrangement.
- DO NOT report patients who are part of the foster system program and are placed with a family, group home, or in some other arrangement as homeless.

[14] Health centers may use criteria as defined by HUD to assist in defining permanent supportive housing.

Total School-Based Service Site Patients, Line 24

All health centers that identified a school-based service site in their scope of project (as documented on Form 5B) are to report the total number of patients who received health care services at the approved school-based service delivery site(s). Include patients who received countable visits within any of the service categories (medical, mental health, etc.) when conducted at an approved school-based service site. All patient characteristic details are to be collected and reported.

- Report patients served at in-scope school-based service sites located on school grounds, limited to preschool, kindergarten, and primary through secondary schools (exclude colleges and universities), that provide on-site health services.
- Services are targeted to the students at the school but may also be provided to siblings or parents and may occasionally be provided to school staff or patients residing in the immediate vicinity of the school.
- DO NOT include, as patients, students who only receive screening services or mass treatment, such as vaccinations or fluoride treatments, at a school.
- All health centers that identified a school-based service site in their scope of project report these populations, regardless of whether the health center directly received HRSA-administered school-based service site funding.

Total Veterans, Line 25

All health centers are to report the total number of patients who served in the active military, naval, or air service, which includes full-time service in the Air Force, Army, Coast Guard, Marines, Navy, Space Force, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. In addition, include patients who served in the National Guard or Reserves on active-duty status.

Include this question in the patient information/intake form at each service delivery site.

- Report only those who affirmatively indicate they previously served in these branches of the military or armed forces.
- DO NOT report patients who do not respond, regardless of other indicators.
- DO NOT report veterans of other nations' militaries, even if they served in wars in which the United States was also involved.
- DO NOT report military members who served on active duty (full-time status in their military capacity) at the time of their last visit during the year.

Total Patients Served at a Health Center Service Delivery Site Located in or Immediately Accessible to a Public Housing Site, Line 26

All health centers are to report **all patients seen at a service delivery site located in or immediately accessible to public housing**, regardless of whether the patients are residents of public housing or the health center receives funding under section 330(i) (PHPC).

- Report patients on this line if they are served at health center **service delivery sites** that meet the statutory definition for the PHPC program (located in or immediately accessible to public housing).
- Report all patients seen at the health center service delivery site if it is located in or immediately accessible to agency-developed, -owned, or -assisted low-income housing, including mixed-finance projects.

- This is the only field in the UDS Report that requires you to **provide a count of all patients based on the health center service delivery site's proximity to public housing**.
- DO NOT consider Section 8 housing units that receive no public housing agency support other than Section 8 housing vouchers as public housing.

Note: Not all patients served at service delivery sites located in or immediately accessible to public housing are themselves residents of public housing, but they are to be included in the count.

FAQ FOR TABLE 4

1. **Do we determine a patient's income relative to the FPG based on the location of the health center or based on the residence of the patient?**

   Use the FPG based on the location of the health center. All states (except Alaska and Hawaii) and the U.S. territories use the same standard poverty guidelines. For patients being served in Alaska or Hawaii, use the FPG established for those locations.

2. **Patients who are experiencing homelessness or who are agricultural workers generally DO NOT have income verification. Can we report them as having income at 100% and below poverty?**

   No. You can report them as having "Unknown" income, but not as having income below poverty unless you verify this at least annually. Subject to your health center's financial policies and procedures, you may document their income in your system based on their verbal attestation of their income.

3. **We serve students at a school-based service site. They often DO NOT know what insurance they have, if any, and they have no information on their family's/household's income. Can we report them as having income at 100% and below poverty and Uninsured?**

   No. You may not report them as having income below poverty and Uninsured. Obtain insurance information from the parents or guardians of students served at school-based service sites at the same time that you collect consent to treat, unless they are exclusively receiving minor consent services. Minor consent services are defined by state law and are generally limited to a very specific range of services, such as those related to contraception, sexually transmitted diseases, and mental health. Not all states provide for them. For all other services, children will require parental consent, and the consent form should include income and insurance information.

   Note: Subject to the health center's policies and procedures, it is acceptable to ask for this information and to assure parents that you will not bill the insurance without their knowledge. If you DO NOT obtain the family's/household's income, report the child as having "Unknown" income. The patient's health insurance information is required to be collected, even if it is not billed.

4. **If a patient is seen only for dental care, do we report the patient's dental insurance on Lines 7–12?**

   No. Table 4 reports only patients' medical coverage. All health centers must collect medical coverage information from all patients, even if they have not been provided medical services.

5. **Our state is using Medicaid expansion provisions to assist patients with buying private insurance. Should we count them as Medicaid or Private?**

   If patients are Medicaid expansion patients, report them as Medicaid, Line 8a (this may require looking for specific plan numbers or other identifying characteristics in patients' insurance enrollment). If you are unable to identify Medicaid expansion patients, report them as Private, Line 11.

6. Do we classify patients in the insurance section as Uninsured if their medical insurance did not pay for the visit?

No. Always report patients based on their primary medical care insurance, even if the insurance did not pay or you are unable to bill for the service. Some examples follow:

- Report a patient with Medicare who was seen for a dental visit that was not paid for by Medicare as having Medicare for this table.
- Report a patient with private insurance who had not reached their deductible as a Private Insurance patient.

7. Is it possible to have more members in one month (average) than total patients in an insurance category?

It is possible for the number of member months for any one payer (e.g., Medicaid) to exceed 12 times the number of patients reported on the corresponding insurance line, especially when patients are enrolled in the managed care plan but they did not come to the health center during the calendar year. As a rule, there is a relationship between the member months reported on Lines 13a and 13b and the insured patients reported on Lines 7 through 11.

8. If we do not receive direct funding under the HCH, MHC, or PHPC programs, do we need to report the total number of special population patients served?

Yes. Even health centers that DO NOT receive grant funding for special populations are required to complete the following:

- Line 16 (the total number of patients seen during the calendar year who were agricultural workers or their family members)—but not Lines 14 and 15,
- Line 23 (total number of patients known to have experienced homelessness at any time of the year and received services during the calendar year)—but not Lines 17–22,
- Line 24 (patients served at a school-based service site),
- Line 25 (veterans), and
- Line 26 (total number of patients served at a health center located in or immediately accessible to a public housing site).

The housing status details on Lines 17–22 are grayed out if you did not receive HCH funding—only enter the total on Line 23.

The migratory and seasonal agricultural workers details on Lines 14 and 15 are grayed out if you did not receive MHC funding—only enter the total on Line 16.

9. What timing determines a patient's homeless status and shelter arrangement?

For all health centers (regardless of HCH funding status), include the total number of patients who experienced homelessness at any point during the year and received services during the year on Line 23.

For awardees that receive HCH funding, continue to count patients seen who are no longer experiencing homelessness due to becoming residents of permanent housing for 12 months after their last visit as homeless.

For awardees that receive HCH funding, report all patients experiencing homelessness by their shelter arrangement on Lines 17–22.

Asking health centers to report patients experiencing homelessness by their sheltering arrangements as of their first visit during the calendar year is intended to help health centers determine to which shelter arrangement they should report a patient if shelter status changes during the year.

10. Who should be reported as Patients Served at a Health Center Located in or Immediately Accessible to a Public Housing Site on Line 26?

Report the total number of patients who were served at any health center service delivery site **that you consider** (based on the health center's determination if any service delivery locations meet the statutory definition for PHPC) to be located in or immediately accessible to public housing, regardless of whether or not the health center receives funding under section 330(i) (PHPC), and regardless of whether or not patients resided in public housing. This is a site-based count, and the patient's address or residence in public housing is not to be considered.

11. We currently ask if a patient is a veteran as part of the registration process, but we are concerned that not all veterans are responding accordingly. Are there suggestions?

Yes. The way the question is asked makes a difference, and improving the wording can improve accuracy in the patients' response to veteran status. The National Association of Community Health Centers (NACHC) provides recommended wording for veteran status screening questions to improve the data collected.

12. Are patients who were dishonorably discharged or released considered veterans?

No. Only patients who were discharged or released under conditions other than dishonorable are considered and reported as veterans.

13. Do the totals need to equal other sections or tables?

The following totals must be equal across tables and sections:

- Patients by ZIP Code Table, Column B must equal Table 4, Line 7, Columns A and B.
- Patients by ZIP Code Table, Column C must equal Table 4, Lines 8 and 10, Columns A and B.
- Patients by ZIP Code Table, Column D must equal Table 4, Line 9, Columns A and B.
- Patients by ZIP Code Table, Column E must equal Table 4, Line 11, Columns A and B.
- The sum of Table 3A, Line 39, Columns A and B (total patients by age and sex) must equal Table 3B, Line 8, Column D (total patients by race and Hispanic, Latino/a, or Spanish ethnicity); Table 4, Line 6 (total patients by income); and Table 4, Line 12, Columns A and B (total patients by medical insurance status).
- The sum of Table 3A, Lines 1–18, Columns A and B (total patients age 0–17 years) must equal Table 4, Line 12, Column A (total patients age 0–17 years).
- The sum of Table 3A, Lines 19–38, Columns A and B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).
- The sum of Table 3A, Line 39, Columns A and B (total patients by age and sex) must equal Table 4, Line 12, Columns A and B (total patients by insurance status).

The same is true for each of the Grant Reports submitted.

TABLE 4: SELECTED PATIENT CHARACTERISTICS

Calendar Year: January 1, 2024, through December 31, 2024

Line	Income as Percentage of Poverty Guideline	Number of Patients (a)
1	100% and below	
2	101–150%	
3	151–200%	
4	Over 200%	
5	Unknown	
6	**TOTAL** (Sum of Lines 1–5)	

Line	Primary Third-Party Medical Insurance	0–17 years old (a)	18 and older (b)
7	**None/Uninsured**		
8a	Medicaid (Title XIX)		
8b	CHIP Medicaid		
8	**Total Medicaid** (Line 8a + 8b)		
9a	Dually Eligible (Medicare and Medicaid)		
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)		
10a	Other Public Insurance (Non-CHIP) (specify___)		
10b	Other Public Insurance CHIP		
10	**Total Public Insurance** (Line 10a + 10b)		
11	**Private Insurance**		
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)		

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months					
13b	Fee-for-service Member Months					
13c	**Total Member Months** (Sum of Lines 13a + 13b)					

TABLE 4: SELECTED PATIENT CHARACTERISTICS (CONTINUED)

Calendar Year: January 1, 2024, through December 31, 2024

Line	Special Populations	Number of Patients (a)
14	Migratory (330g awardees only)	
15	Seasonal (330g awardees only)	
16	**Total Agricultural Workers or Their Family Members** (All health centers report this line)	
17	Homeless Shelter (330h awardees only)	
18	Transitional (330h awardees only)	
19	Doubling Up (330h awardees only)	
20	Street (330h awardees only)	
21a	Permanent Supportive Housing (330h awardees only)	
21	Other (330h awardees only)	
22	Unknown (330h awardees only)	
23	**Total Homeless** (All health centers report this line)	
24	**Total School-Based Service Site Patients** (All health centers report this line)	
25	**Total Veterans** (All health centers report this line)	
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	

Table 4 Cross-Table Considerations:

- The total patients reported by insurance type must match on Table 4 (Lines 7–12) and the Patients by ZIP Code Table. For example, total Medicare patients on Table 4 (Line 9) must match the total of the Medicare Column D on the Patients by ZIP Code Table.
- Charges and collections by payer on Table 9D relates to insurance enrollment on Table 4. For example, dividing Medicaid revenue on Table 9D, Line 3, Column B by Total Medicaid Patients on Table 4, Line 8 equals the average collection per Medicaid patient.
- Reporting of managed care revenue on Table 9D relates to member months on Table 4. Dividing managed care capitation revenue by member months equals average capitation per member per month (PMPM). For example, dividing Medicaid capitated revenue (Table 9D, Line 2a, Column B − (c1 + c2 + c3 − c4)) by Table 4, Line 13a, Column A equals Medicaid PMPM.
- If you submit Grant Reports, the total number of patients reported on the grant table(s) must be less than or equal to the corresponding number on the Universal Report for each cell.

Instructions for Table 5: Staffing and Utilization

Table 5 and the Selected Service Detail Addendum collect data on services provided to patients during the calendar year. There are no major changes to this table.

TABLE 5: STAFFING AND UTILIZATION – INSTRUCTIONS

This table provides a profile of health center personnel (Column A), the number of clinic (in-person) visits they render (Column B), the number of virtual visits they render (Column B2), and the number of unduplicated patients served in each service category (Column C).

Service categories that may reflect visits and patients include:

- Medical
- Dental
- Mental health
- Substance use disorder
- Other professional
- Vision
- Enabling

The patient count will often involve duplication across service categories (e.g., a patient may be reported in both medical and dental patient counts), though it is always unduplicated within service categories (e.g., regardless of number of medical visits or types of medical providers seen, the patient is only counted once as a medical patient). This is unlike the Patients by ZIP Code Table and Tables 3A, 3B, and 4, where an unduplicated count of patients across all service categories is reported.

The major staffing service categories on Table 5 are consistent with cost categories used for financial reporting and provide adequate detail on personnel categories for program planning and evaluation purposes.

Personnel full-time equivalents (FTEs) in Column A is reported only on the Universal Report table, not the Grant Report tables. Grant Reports provide data on patients served in whole or in part with section 330(h) (HCH), section 330(g) (MHC), and/or section 330(i) (PHPC) funding and the visits they had during the year. This includes all visits supported with grant and non-grant funds.

PERSONNEL FTES, COLUMN A

Table 5 includes personnel FTE for all individuals who work in programs and activities that are within Form 5B of the health center's scope of project for all service delivery sites included in the UDS. Report all personnel in terms of **annualized** FTEs.

- Report FTEs of all personnel supporting health center operations defined by the scope of project in Column A. Personnel may provide services on behalf of the health center under many different arrangements, including but not limited to salaried full-time, salaried part-time, hourly wages, National Health Service Corps (NHSC) assignment, under contract (paid based on hours worked or FTE), interns, residents, preceptors, or donated time (volunteers).

- DO NOT report FTEs for individuals who are paid by the health center on a fee-for-service basis in the FTE column, because their work is not based on time and there is no basis for determining their hours. Visits with providers paid through this arrangement are still reported in Column B or B2 and the patients who received those services are reported in Column C.

Identifying Employment Type and Calculating FTEs

The following describes the basis for determining someone's employment type for purposes of reporting on FTEs:

- One FTE (1.00) describes personnel who worked the equivalent of full-time for one full year. Each health center defines the number of hours for "full-time" work and may define it differently for different positions.
- The FTE is based on employment agreements for providers and other personnel.
- In some health centers, different positions have different definitions of full time. Positions with different time expectations should be calculated on whatever they have as a base for that position. Some positions, per employment contracts, consider working 36 hours per week full time and would be considered 1.00 FTE. In this case, an 18-hour-per-week personnel would be considered 0.50 FTE regardless of whether other personnel in other positions work 40-hour weeks.
- The FTE of personnel receiving full-time benefits for the full year would be considered full-time = 1.00 FTE.
- Hourly personnel who work more than full-time (i.e., overtime) will have an FTE greater than 1.00.
- For personnel who do not receive all of the paid time off of full-time personnel (i.e., vacation, holidays, and sick benefits), the effective FTE is calculated by dividing worked hours by adjusted full-time hours (full-time hours minus paid time off hours that full-time personnel receive).

Reporting FTEs on the Appropriate Line on Table 5

Allocate all personnel time by **function** among the major service categories listed. DO NOT parse out the components of an encounter. The nurse who handles a referral after a visit as a part of that visit would not be allocated out of nursing. The nurse who collects vitals on a patient, who is then placed in the exam room, and later provides instructions on wound care, for example, would not have a portion of the time counted as health education—it is all a part of nursing.

Report an individual who is employed as a full-time provider for a full year as 1.00 FTE regardless of the number of direct patient care hours they provide. Providers who have released time to compensate for on-call hours, have weekly administrative sessions when they DO NOT see patients, or receive paid leave for continuing education or other reasons are still considered full-time per their employment contract. Similarly, DO NOT count providers who are routinely required to work more than 40 hours per week as more than 1.00 FTE.

Note: Count loan-repayment recipients as full-time. Also note that the FQHC Medicare intermediary has different definitions for full-time providers; these are NOT to be used for UDS reporting.

The time spent by providers performing tasks in what could be considered non-direct-service clinical activities, such as charting, reviewing labs, filling or renewing prescriptions, returning phone calls, arranging for referrals, participating in quality improvement (QI) activities, supervising, etc., is all considered part of their overall medical care services time and should not be separately reported in a non-clinical support category.

The one exception to this rule is when a chief medical officer/medical director is engaged in non-clinical activities at the **corporate level** (e.g., attending board of directors or senior management meetings, advocating for the health center before the city council or Congress, writing grant applications, participating in labor negotiations, negotiating fees with insurance companies), in which case time can be allocated to the non-clinical support services category. This does not, however, include non-clinical activities in the medical area, such as supervising

the clinical personnel, chairing or attending clinical meetings, developing clinical schedules, or writing clinical protocols.

Example FTE calculations are provided in the FAQ for Table 5 and Selected Service Detail Addendum.

Personnel by Major Service Category

Personnel are distributed into categories that reflect the types of services they provide as independent providers. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare. The following summarizes the personnel categories; a more detailed, though not exhaustive, list appears in Appendix A.

Medical Care Services (Lines 1–15)

Physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) who are a primary source of medical care delivery, as permitted under their license, are included as medical providers. Supporting medical personnel include nurses and other medical, medical laboratory, and medical X-ray personnel.

- **Physicians (Lines 1–7)**
  - Report physicians on Lines 1–7 consistent with their licensure. Physicians with dual boarding may be allocated into two lines, such as internal medicine and pediatrics, based on time spent or patients seen, but both provider FTE and visits must be allocated.
  - Report licensed interns and residents on the line for the specialty designation they are working toward and credit them with their own visits. (Thus, count a family practice resident as a family physician on Line 1.)
  - DO NOT report psychiatrists, ophthalmologists, pathologists, or radiologists here. They are separately reported on Lines 20a, 22a, 13, and 14, respectively.
  - DO NOT report naturopaths, acupuncturists, community and behavioral health aides/practitioners, or chiropractors on these lines. Report these providers on Line 22 (Other Professionals).
- **Nurse Practitioners (Line 9a)**
  - Report NPs, advanced practice registered nurses (APRNs), and advanced practice nurses on Line 9a.
  - DO NOT report psychiatric NPs (included on Line 20b, Other Licensed Mental Health Providers) or CNMs, (reported on Line 10) on this line.
- **Physician Assistants (Line 9b)**
  - Report PAs on Line 9b.
  - DO NOT include psychiatric PAs here (included on Line 20b, Other Licensed Mental Health Providers).
- **Certified Nurse Midwives (Line 10)**
  - Report CNMs on Line 10.
- **Nurses (Line 11)**
  - Report licensed registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses.

- **Other Medical Personnel (Line 12)**
  - Report medical assistants, nurses' aides, and all other personnel, including unlicensed interns or residents, providing services in conjunction with services provided by a physician, NP, PA, CNM, or nurse.
  - DO NOT report non-medical personnel here.
    - DO NOT report personnel dedicated to QI or health IT/EHR informatics here. Report them on Line 29b, Quality Improvement Personnel.
    - DO NOT report patient health records or patient support personnel here. Report them on Line 32, Patient Support Personnel.
- **Laboratory Personnel (Line 13)**
  - Report pathologists, medical technologists, laboratory technicians and assistants, and phlebotomists.
  - Some or all of nurses' time may be in this category if they have dedicated times that they are assigned to this responsibility.
  - DO NOT report the time of a physician (except a pathologist) here.
- **X-ray Personnel (Line 14)**
  - Report radiologists, X-ray technologists, and X-ray technicians.
  - DO NOT include physician time (except radiologists) here, even if they were taking or reading X-rays or performing sonograms.

Dental Services (Lines 16–19)

- **Dentists (Line 16)**
  - Report general practitioners, oral surgeons, periodontists, and endodontists providing prevention, assessment, or treatment of a dental problem, including restoration.
- **Dental Hygienists (Line 17)**
  - Report licensed dental hygienists.
- **Dental Therapists (Line 17a)**
  - Several states and American Indian or Alaska Native communities license dental therapists.
  - Report personnel on this line only if they have a state license or tribal designation as such.
- **Other Dental Personnel (Line 18)**
  - Report dental assistants, advanced dental assistants, aides, and technicians.

Behavioral Health Services

The term "behavioral health" is synonymous with the prevention or treatment of mental health and substance use disorders. All visits, providers, and patients classified by health centers as "behavioral health" must be parsed into mental health or substance use disorders. Centers may choose to identify all behavioral health services as Mental Health Services if there is no way to reasonably split these services.

Mental Health Services (Lines 20a–20c)

Mental health services include psychiatric, psychological, psychosocial, or crisis intervention services.

- **Psychiatrists (Line 20a)**

- **Licensed Clinical Psychologists (Line 20a1)**
- **Licensed Clinical Social Workers (Line 20a2)**
- **Other Licensed Mental Health Providers (Line 20b)**
    - Report other **licensed** mental health providers, including psychiatric social workers, psychiatric NPs, family therapists, and other licensed master's degree–prepared providers.
- **Other Mental Health Personnel (Line 20c)**
    - Report unlicensed personnel and support personnel, including "certified" personnel, who provide counseling or treatment, or who support mental health providers.
    - Unlicensed interns or residents in any of the professions listed on Lines 20a through 20b are reported on Line 20c, unless they possess a separate license under which they are practicing. Thus, a licensed clinical social worker (LCSW) doing a psychology internship may be reported on Line 20a2 until they receive a license to practice as a psychologist.

Substance Use Disorder Services (Line 21)

- Report personnel who provide substance use disorder services, including substance use disorder social workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, alcohol and drug abuse counselors, family therapists, and other individuals providing substance use disorder counseling and/or treatment services.
- Neither licenses nor credentials are required by the UDS for substance use disorder personnel. Substance use disorder providers are credentialed according to the state's and health center's standards.
- Report medical providers treating patients with substance use diagnoses in the medical services category on Lines 1 through 10, NOT as substance use disorder providers. Additional information about substance use disorder treatment by medical providers is collected in the Selected Service Detail Addendum to this table.
- DO NOT report physicians, NPs, PAs, CNMs, or Certified Registered Nurse Anesthetists who completed the one-time training on substance use disorder treatment required under the Medication Access and Training Expansion Act and/or have a current Drug Enforcement Administration registration that includes Schedule III authority to provide medications for opioid use disorder (MOUD) here. Report MOUD providers on Lines 1–10 (if medical), Line 20a for psychiatrists, or Line 20b for psychiatric NPs. Additional information about MOUD services is collected in Appendix E: Other Data Elements.

Other Professional Health Services (Line 22)

Other professional personnel may provide an array of services and care important to primary and other care delivery that support or complement the services of other providers.

- Report personnel who provide other professional health services. Some common professions include occupational, speech, and physical therapists; respiratory therapists; registered dieticians; nutritionists; podiatrists; naturopaths; chiropractors; acupuncturists; and community and behavioral health aides/practitioners. A more complete list is included in Appendix A.
- These professionals are generally credentialed and privileged by the health center's governing board to act in accordance with their approved job descriptions.
- DO NOT report other professionals working in the WIC programs here. Report WIC nutritionists and other professionals working in WIC programs on Line 29a, Other Programs and Services Personnel.

Vision Services (Lines 22a–22d)

Report providers who perform eye exams for detection, care, treatment, and prevention of vision problems, including those that relate to chronic diseases such as diabetes, hypertension, thyroid disease, and arthritis, or for the prescription of corrective lenses.

- **Ophthalmologists (Line 22a)**
  - Report MDs specializing in the provision of medical and surgical eye care.
- **Optometrists (Line 22b)**
  - Report doctors of optometry (OD) who provide routine eye care services.
- **Other Vision Care Personnel (Line 22c)**
  - Report ophthalmologist and optometric assistants, aides, and technicians.

Pharmacy Services (Lines 23a–23d)

- Report personnel supporting pharmaceutical services.
- DO NOT report the time (or cost) of personnel spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies through patient assistance programs (PAPs) here. Report them on Line 27a, Eligibility Assistance Workers. If personnel work as a pharmacy assistant, for example, and also provide PAP enrollment assistance, allocate time spent in each category.
- DO NOT include time for individuals who work at a 340B contract pharmacy, since they are paid fee-for-service, and not based on time.
- DO NOT report personnel who manage pharmacy 340B contracts here. Report them on Line 30a as non-clinical support personnel.
- **Pharmacists (Line 23a)**
  - Report pharmacists supporting pharmaceutical services, such as dispensing medications prescribed by health care providers, providing pertinent drug information to health care teams and providers, and informing patients about proper usage of medications and side effects.
- **Clinical Pharmacists (Line 23b)**
  - Report licensed clinical pharmacists, including board certified specialties (e.g., board certified pharmacotherapy specialist, ambulatory care) on Line 23b. DO NOT allocate to other clinical or non-clinical lines.
- **Pharmacy Technicians (Line 23c)**
  - Report fully licensed pharmacy technicians.
- **Other Pharmacy Personnel (Line 23d)**
  - Report pharmacist assistants and other supporting pharmaceutical services.

Enabling Services (Lines 24–29)

- **Case Managers (Line 24)**
  - Report personnel who assist patients in the management of their health and social needs, including assessment of patient medical and/or social service needs; establishment of service plans; and maintenance of referral, tracking, and follow-up systems.

  - Include personnel who are trained as—and specifically called—case managers, as well as individuals called care coordinators, referral coordinators, and other local titles.
  - Case managers may provide health education and/or eligibility assistance in the course of their case management functions. DO NOT parse out this time unless the personnel have dedicated time to other enabling service categories.

- **Health Education Specialists (Line 25)**
  - Report patient and community health educators with or without specific degrees.
- **Outreach Workers (Line 26)**
  - Report personnel conducting case finding, education, or other services designed to identify potential patients or clients and/or facilitate access or referral of potential health center patients to available health center services.
- **Transportation Workers (Line 27)**
  - Report personnel who provide transportation for patients (e.g., van drivers) or arrange for transportation (e.g., for bus or taxi vouchers), including personnel who arrange for local transportation or longer-distance transportation to major cities in extremely remote clinic locations.
- **Eligibility Assistance Workers (Line 27a)**
  - Report personnel (e.g., patient navigators, certified assisters, eligibility workers) who provide assistance in securing access to available health, social service, pharmacy, and other assistance programs, including Medicaid, Medicare, WIC, Supplemental Security Income (SSI), food stamps through the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), PAPs, and related assistance programs, as well as personnel hired under the HRSA Outreach and Enrollment grants.
- **Interpretation Personnel (Line 27b)**
  - Report personnel whose full-time or dedicated time is devoted to translation and/or interpretation services.
  - DO NOT include the portion of the time a nurse, medical assistant, or other support personnel providing interpretation, translation, or bilingual services during their other activities.
- **Community Health Workers (Line 27c)**
  - Report lay members of communities who work in association with the local health care system in urban or rural environments and usually share ethnicity, language, socioeconomic status, and/or life experiences with the community members they serve. Personnel may be called community health workers, community health advisors, lay health advocates, promotoras, community health representatives, peer health promoters, or peer health educators.
  - They may perform some or all of the tasks of other enabling services workers. If some of their time is dedicated to these other functions, report them on those lines.
  - DO NOT include personnel better classified under other service categories, such as Other Medical Personnel (Line 12) or Other Dental Personnel (Line 18).
- **Personnel Performing Other Enabling Service Activities (Line 28)**
  - Report all other personnel performing enabling services not described above. Complete the "specify" field to describe the personnel positions.
  - If a service does not fit the strict descriptions for Lines 24 through 27c, its inclusion on Line 28 must include a clear detailed statement of what is being reported.

- DO NOT use enabling services, especially Other Enabling Services (Line 28), as a catchall, all-inclusive category for services that are not included on other lines. Often, such services belong on Line 29a (Other Programs and Related Services Personnel) or are services that are not separately reported on the UDS.
- Check such services with the UDS Support Center prior to submission.

Other Programs and Related Services Personnel (Line 29a)

Some health centers operate programs that (although within their scope of project and often important to the overall health of their patients) are not directly a part of the listed medical, dental, behavioral, or other professional health services (also referred to as "umbrella agencies").

- Report personnel for these programs, such as WIC programs, job training programs, Head Start or Early Head Start programs, shelters, housing programs, child care, frail elderly support programs, adult day health care (ADHC) programs, fitness or exercise programs, public/retail pharmacies, etc., on this line. Complete the "specify" field to describe the personnel positions.

Quality Improvement Personnel (Line 29b)

Although QI is a part of virtually all clinical and administrative positions, some individuals have specific responsibility for the design and oversight of QI systems.

- Report individuals that spend all or a substantial portion of their time dedicated to these activities. They may have clinical, information technology (IT), or research backgrounds, and may include QI nurses, data specialists, statisticians, and designers of health IT (including EHRs and electronic medical records [EMRs]).
- Report personnel who support health IT to the extent that they are working with the QI system on Line 29b.
- Continue to report personnel who document services in the health IT in the appropriate service category, not here.
- DO NOT include on this line the time of providers, such as physicians or dentists, who are also involved in the QI process. Their time is to remain on the service category lines.

Non-Clinical Support Services (Lines 30a–32)

- **Management and Support Personnel (Line 30a)**
  - Report the management team, including the CEO, chief financial officer (CFO), chief information officer (CIO), chief medical officer (CMO), chief operations officer (COO), and human resources (HR) director, as well as other non-clinical administrative support and office support personnel.
  - For medical directors or other personnel whose time is split between clinical and non-clinical activities, report here only that portion of their FTE corresponding to the corporate management function. (See limits on non-clinical time under Personnel Full-Time Equivalents.)
- **Fiscal and Billing Personnel (Line 30b)**
  - Report personnel performing accounting and billing functions in support of health center operations for services performed within the scope of project.
  - DO NOT include the CFO here. Report the CFO on Line 30a, Management and Support Personnel.
- **IT Personnel (Line 30c)**
  - Report information systems technical personnel who maintain and operate the computing systems that support functions performed within the scope of project.

  - Report IT personnel managing the hardware and software of a health IT (including EHR/EMR) system on Line 30c.
  - Report IT personnel performing data entry and providing training and technical assistance functions as part of the other medical personnel or appropriate service category for which they perform these functions.
  - DO NOT report IT personnel designing medical forms and conducting analysis of health IT data here. Report as part of the QI functions on Line 29b.
- **Facility Personnel (Line 31)**
  - Report personnel with facility support and maintenance responsibilities, including custodians, housekeeping personnel, groundskeepers, security personnel, and other maintenance personnel. If facility functions are contracted (e.g., janitorial services), DO NOT include an FTE; but report the contracted costs on Line 14 on Table 8A.
- **Patient Services Support Personnel (Line 32)**
  - Report intake personnel, front desk personnel, and patient health records personnel.

Note: The non-clinical category for this report is more comprehensive than that used in some other program definitions and includes **all** such personnel working in a health center, whether an individual's salary was supported by HRSA's BPHC grant or other funds included in the scope of project. Where appropriate, and when identifiable, report personnel included in a health center's federally approved budget indirect cost rate here.

VISITS, COLUMNS B AND B2

Report only clinic (in-person) and virtual visits that meet the countable visit definitions, as described in the Instructions for Tables that Report Visits, Patients, and Providers section of the UDS Manual.

Report Clinic Visits (Column B) and Virtual Visits (Column B2). These are mutually exclusive, and total visits are calculated by adding Columns B and B2.

Clinic Visits, Column B

- Report any documented **in-person** encounter between a patient and a licensed or credentialed provider who exercises their independent professional judgment in the provision of services to the patient at that time as a **visit** in Column B.
- Report all such visits that occurred during the calendar year rendered by salaried, contracted, or volunteer providers. Report visits on the same line as the provider who conducted the visit. Most visits reported in Column B will be provided by personnel identified in Column A.
- Visits purchased from contracted providers on a fee-for-service basis should also be reported, even though the FTE of the provider is not reported.

Note: DO NOT report encounters that are screenings, tests, or vaccines (such as for COVID-19) as visits. Only report encounters that meet the full definition as a visit.

Virtual Visits, Column B2

- Report any documented **virtual (telemedicine)** encounter between a patient and a licensed or credentialed provider who exercises their independent professional judgment in the provision of services to the patient at that time as a **visit** in Column B2.

- Report all such visits that occurred during the calendar year rendered by salaried, contracted, or volunteer personnel. Report visits on the same line as the provider who conducted the visit. Most visits reported in Column B2 will be provided by personnel identified in Column A.
- Virtual visits purchased from contracted providers on a fee-for-service basis should also be reported.

Note: Telemedicine is a growing model of care delivery. It is important to remember that payer, state, and federal telehealth definitions, regulations, and billing requirements regarding the acceptable modes of care delivery, types of providers, informed consent, and location of the patient and/or provider are not applicable in determining virtual patient visits for UDS reporting.

Virtual Visit Considerations

- Virtual visit reporting should be consistent with the health center's scope of project.
- Virtual visits must meet the countable visit definition.
- All reporting requirements regarding multiple visits in the same service category in the same day apply, **except** that two different providers based out of two different in-scope service delivery sites may be reported as two visits.
- Report virtual visits where:
  - The health center provider provided care to a patient who was elsewhere (i.e., not physically at the health center).
  - The health center patient received services through telemedicine by a non–health center provider paid for by the health center or by a volunteer provider who was at the health center.
  - The provider was not physically present at the health center when providing care to the patient, who was in a separate location. The provider must have had remote access to the patient's health record at the time of the visit to review it and record their activities.
  - Interactive, synchronous audio or audio-video telecommunication systems that permit real-time communication between the provider and the patient were used.
  - Services are coded and charged as telehealth services, even if a third-party payer does not recognize or pay for such services. Generally, these charges would be similar to a comparable clinic (in-person) visit charge.

Note: Use codes that will result in accurate identification of virtual visits. These include telehealth-specific codes **with** the CPT or Healthcare Common Procedure Coding System (HCPCS) codes such as G0071, G0406-G0408, G0425-G0427, G2025, modifier ".95," modifier "93" (audio-only medical services), or Place of Service code "02" to identify virtual visits.

- DO NOT report:
  - as a virtual visit situations in which the health center does not pay for virtual services provided by a non–health center provider (referral),
  - other modes of telemedicine services (e.g., store and forward, remote patient monitoring, mobile health) or provider-to-provider consultations,
  - a separate clinic (in-person) visit at the originating clinic, or
  - a follow-up call for a health status check following an earlier appointment.

Visits Purchased from Non-Personnel Providers on a Fee-For-Service Basis

Report these visits in Column B (clinic) or B2 (virtual) even though no corresponding FTEs are included in Column A. To count, the visit must meet the following criteria:

- the service was provided to a patient of the health center by a provider who is not part of the health center's personnel (neither salaried, volunteer, nor contracted on the basis of time worked) although they meet the center's credentialing policies,
- the service was paid for in full by the health center, and
- the service otherwise met the definition of a visit.

DO NOT include unpaid referrals, referrals where a third party (e.g., the patient's insurance company) will make the payment directly to the provider, or referrals where only nominal amounts, including facility fees, are paid although the negotiated payment may be less than the provider's "usual, customary, and reasonable" (UCR) rates.

Visit Considerations by Personnel Line

Nurses, Line 11

- Services may be provided under standing orders of a medical provider, under specific instructions from a previous visit, or under the general supervision of a physician, NP, PA, or CNM who has no direct contact with the patient during the visit. These services must meet the requirement of exercising independent professional judgment.
- Report nurse visits that meet all visit criteria. See instructions for Countable Visits. Note that most patient services provided by a nurse DO NOT meet the full visit criteria.
- Report triage services provided by nurses and visiting nurse services when a nurse sees patients independently in the patients' homes to evaluate their condition(s).
- Report visits charged and coded as CPT 99211 only when all components of UDS countable visit requirements were met.
- DO NOT report a service if it is a follow-up or completion of services from another visit (e.g., nurse calls to check up on how a patient is doing after a visit, nurse checks wound or removes sutures, nurse provides vaccines), even if it occurs at a later date.
- DO NOT report encounters with a nurse where the primary purpose is to conduct a lab test, give an injection, or dispense or administer a drug, regardless of the level of observation needed, as a visit.
- Most states prohibit a licensed vocational nurse or licensed practical nurse from exercising independent professional judgment; DO NOT count visits for them.

Dentists, dental hygienists, and dental therapists, Lines 16, 17, and 17a

- Report only one visit per patient per day, regardless of the number of dental providers who provide services (e.g., dentist and dental hygienist both see the patient) or the volume of service (i.e., number of procedures) provided.
- DO NOT report the application of dental varnishes, fluoride treatments, or dental screenings, absent other comprehensive dental services, as a visit.
- DO NOT report as a dental visit medical providers who examine a patient's dentition or provide fluoride treatments.

- DO NOT report as a dental visit a phone call between the patient and provider for a follow-up on a completed procedure or service.
- DO NOT credit services of dental students or anyone other than a licensed dental provider with dental visits, even if these individuals are working under the supervision of a licensed dental provider.
- Exception: Report the visits of a supervising dentist's student (i.e., the dentist is overseeing dental students enrolled in a graduate education program leading to a license as a dentist) as long as the supervising dentist:
  - has no other responsibilities, including the supervision of other personnel, at the time services are furnished by the students;
  - has primary responsibility for the patients;
  - reviews the care furnished by the students during or immediately after each visit; and
  - documents the extent of their participation in the review and direction of the services furnished to each patient.

Other mental health, Line 20c

- Report visits with unlicensed mental health personnel regardless of any billing practices at the center. DO NOT report their visits elsewhere.

Substance use disorder, Line 21

- In programs that include the regular use of narcotic agonists or antagonists or other medications on a regular basis (daily, every three days, weekly, etc.), report only the individualized or group counseling services, not the dispensing of medications, as visits.
- DO NOT report the counseling by medical or psychiatric providers of patients to determine or diagnose their medical needs, including medication assistance and substance use disorder visits, here. Report as medical or psychiatry visits based on the provider of these services.
- DO NOT report the dispensing of drugs, regardless of the level of oversight that occurs during that activity.

Other professional, Line 22

- Report visits by other professional health service providers included in Appendix A.
- Describe these services in a clear, detailed statement using the "specify" box.
- Verify the appropriateness of reporting other professional services with the UDS Support Center or UDS Reviewer.

Vision services, Lines 22a–22d

- DO NOT report the services of students or anyone other than a licensed vision service provider as vision services visits.
- DO NOT report retinography (imaging of the retina), whether performed by a licensed vision service provider or anyone else, as a visit unless accompanied by a comprehensive vision exam.
- DO NOT report fitting glasses as a visit, regardless of who performs the fitting.

Pharmacy, Line 23

- Pharmacy personnel are not considered providers on the UDS (see Appendix A), and therefore visits are NOT reported.

- Some states license clinical pharmacists whose scope of practice may include ordering labs and reviewing and altering medications or dosages. Despite this expanded scope of practice, DO NOT report clinical pharmacist encounters with patients as visits.

Case managers, Line 24

- Case management visits must be documented in the patient's health record.
- When a case manager serves an entire family (e.g., helping with housing or Medicaid eligibility), report only one visit, generally for an adult member of the family, regardless of documentation in other charts.
- Case management is rarely the only type of service provided to a patient during the year.
- Case managers often contact third parties in the provision of their services. DO NOT count these interactions as visits.

Health education, Line 25

- Report only services provided one-on-one with the patient.
- Health education is provided to support the delivery of other health care services and is rarely the only type of service provided to a patient during the year.
- DO NOT report group or community education classes or visits.

DO NOT Report Visits or Patients for Services Provided by the Following:

- Other Medical Personnel, Line 12
- Laboratory Personnel, Line 13
- X-ray Personnel, Line 14
- Other Dental Personnel, Line 18
- Other Vision Care Personnel, Line 22c
- Pharmacy Personnel, Line 23
- Outreach Workers, Line 26
- Transportation Personnel, Line 27
- Eligibility Assistance Workers, Line 27a
- Interpretation Personnel, Line 27b
- Community Health Workers, Line 27c
- Other Enabling Services, Line 28
- Other Programs and Services, Line 29a
- Quality Improvement Personnel, Line 29b
- Management and Support Personnel, Line 30a
- Fiscal and Billing Personnel, Line 30b
- IT Personnel, Line 30c
- Facility Personnel, Line 31
- Patient Support Personnel, Line 32

Additionally, some encounters cannot be reported as countable visits regardless of who provides them. Please review the Services and Individuals NOT Reported on the UDS Report section for specifics.

Note: Columns B and B2 are grayed out on the lines listed above.

PATIENTS, COLUMN C

A patient is an individual who has at least one countable visit during the calendar year. For further details, see the Instructions for Tables that Report Visits, Patients, and Providers section.

- Report an unduplicated patient count in Column C for each of the seven categories of services shown below for which patients had visits reported in Columns B or B2 during the calendar year.
  - Medical services (Line 15)
  - Dental services (Line 19)
  - Mental health services (Line 20)
  - Substance use disorder services (Line 21)
  - Vision services (Line 22d)
  - Other professional services (Line 22)
  - Enabling services (Line 29)
- Report an individual only once as a patient in each service category (e.g., medical, dental) for which they received services, regardless of the number of visits they had or the different providers they saw during the year.
- Because patients must have at least one countable visit, the number of patients cannot exceed the number of visits.
- Patients reported on Table 5 must be included as patients on the demographics tables: Patients by ZIP Code Table and Tables 3A, 3B, and 4.
- DO NOT report individuals who only receive services for which no visits are generated (e.g., laboratory, imaging, pharmacy, transportation, and outreach).

Note: Column C is grayed out on the detail lines within service categories.

SELECTED SERVICE DETAIL ADDENDUM

The Selected Service Detail Addendum to Table 5 provides data on integrated primary care and behavioral health treatment services. Integrated behavioral health reported in the addendum includes:

- mental health services provided by medical providers during medical visits,
- substance use disorder services provided by medical providers during medical visits, and
- substance use disorder services provided by mental health providers during mental health visits.

The addendum is reported on the Universal Report only.

The information reported in the Selected Service Detail Addendum only reflects medical providers and their mental health services **that are NOT already being reported in the mental health section on the main part of Table 5** and medical or mental health providers and their substance use disorder treatment services **that are NOT already being reported in the substance use disorder section on the main part of Table 5**. The sum of mental health and substance use disorder services visits reported in the main part of Table 5 and the addendum to Table 5 provide a combined count of mental health and substance use disorder services provided.

The Selected Service Detail Addendum is divided into two service categories: mental health and substance use disorder detail.

- The Mental Health Services Detail (by type of medical provider), Lines 20a01–20a04, is a subset of medical visits and patients reported on Lines 1–10 in the main section of Table 5.
- The Substance Use Disorder Detail (by type of medical provider), Lines 21a–21d, is a subset of medical visits and patients reported on Lines 1–10 in the main section of Table 5.
- The Substance Use Disorder Detail (by type of mental health provider), Lines 21e–21h, is a subset of mental health visits and patients reported on Lines 20a–20b in the main section of Table 5.

All visits reported in the addendum will also be included in the main part of Table 5 as either medical or mental health visits. Some visits provided by medical providers may include both mental health and substance use disorder treatment and will be counted in each section of the addendum, in addition to being counted as a medical visit in the main part of Table 5.

Note: To identify visits where a mental health or substance use disorder treatment service may have been rendered, include at a minimum all visits in which the reported providers coded International Classification of Diseases, Tenth Revision (ICD-10) codes specified on Table 6A, Lines 18 through 19a for substance use disorder treatment provided as part of a mental health or medical visit and Lines 20a through 20d for mental health treatment provided as part of a medical visit.

Providers, Column A1

- Report the number of **individual providers** (not FTE) by type who provided mental health and/or substance use disorder services. Medical providers can be counted once in each section if they provide both mental health and substance use disorder services.
- If the provider is a contract provider paid by visit or service, DO NOT count an FTE on the main part of Table 5, but count the provider in the addendum.

Clinic Visits, Column B

- Report the number of clinic (in-person) visits, by provider type, where the service in whole or in part included treatment for mental health (on Lines 20a01 through 20a04) or substance use disorder services (on Lines 21a through 21h).

Virtual Visits, Column B2

- Report the number of virtual visits, by provider type, where the service in whole or in part included treatment for mental health (on Lines 20a01 through 20a04) or substance use disorder services (on Lines 21a through 21h).

Patients, Column C

- Report the number of patients seen for a clinic (in-person) or virtual mental health or substance use disorder service by provider(s) in the given line.
- Report patients (and their visits) for each type of provider listed who were seen during the year for these services. This may result in the same patient appearing on more than one line in the addendum.

Note: Total patients provided mental health or substance use disorder treatment services cannot be calculated from the UDS Report, because a patient may be seen by multiple types of providers.

FAQ FOR TABLE 5 AND SELECTED SERVICE DETAIL ADDENDUM

1. **How do we determine FTE?**

   Use employment contracts to determine FTE.

   For employees with full benefits (i.e., vacation, holiday, sick benefits), divide hours paid by what the health center considers to be the base hours for full-time. For example, a physician who, per their employment contract, is only required to work four 9-hour sessions (36 hours) per week, is considered full-time and equals 1.00 FTE.

   For employees with no or reduced benefits, divide hours paid by base hours minus unpaid benefits hours. For example, if the health center provides 10 days for holidays, 12 sick days, 5 continuing medical education (CME) days, and 3 weeks of vacation, that's a total of 336 hours of paid time off. Subtract that from the base calculation. If 2,080 is full time, subtracting 336 hours of paid time off = 1,744 hours. The 1,744 hours becomes the base calculation for employees with no benefits. If this employee is paid for 1,040 hours, when dividing by 1,744 hours the result is 0.59 FTE (reported out to two decimal places).

2. **Our physicians work 35-hour weeks. Do we report as 0.875 (35 divided by 40) FTE?**

   No. Count them as 1.00 FTE. HRSA's BPHC does not require 40-hour workweeks. Use whatever workweek time is considered full-time at your organization. For example, some organizations use 2,080 hours, others use 1,820, and others may have other standards for determining what is full-time.

3. **Do we calculate FTE for personnel with no or reduced benefits the same way we do for personnel receiving full benefits?**

   No. If personnel receive no or reduced benefits, calculate FTE based on paid hours. For example, in a health center that has a 40-hour workweek (2,080 hours/year), an individual who works 20 hours per week all year (i.e., 50% time) is reported as 0.50 FTE; an individual who works full-time for 4 months out of the year is reported as 0.33 FTE (4 months ÷ 12 months). If an individual with no benefits works 2,200 hours out of 2,080 full-time hours, report as 1.06 FTE.

4. **How do I report the FTEs for a provider who regularly sees patients 75% of the time and covers after-hours call for the remaining 25% of their salary?**

   Report personnel who are hired as full-time providers as 1.00 FTE regardless of the number of direct patient care hours they provide. Count as 1.00 FTE providers hired as full-time who have released time to compensate for on-call hours, who have released time to compensate for hours spent on clinical committees, or who receive leave for continuing education or other activities.

   DO NOT adjust for the time spent by a physician (for example) while not in contact with the patient, such as charting, reviewing labs, filling prescriptions, returning phone calls, or arranging for referrals. These tasks are considered part of their time as a physician. The exception to this rule is when a medical director or CMO is engaged in non-clinical activities at the corporate level, in which case time is allocated to the non-clinical category. This does not, however, include non-clinical activities in the medical area, such as chairing or attending meetings, supervising personnel, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals.

5. **Our nurses perform services that cross service categories. Do we allocate the FTE and visit activity accordingly?**

   That depends on if their time is distinctly allocated by function among the major service categories. If, for example, a full-time nurse provides direct medical services and provides some patient education while seeing

the patient for medical care, they would be counted as 1.00 FTE on Line 11 (Nurses). If that nurse provided case management services during 10 dedicated hours per week and provided medical care services for the other 30 hours per week, the time would be allocated as 0.25 FTE case manager (Line 24) and 0.75 FTE nurse (Line 11). Another example includes a nurse who dedicates 20 hours to medical care and 20 hours to providing health education each week would split their 1.00 FTE, with 0.50 FTE as a medical nurse and 0.50 FTE as a health educator.

6. If I report costs for case management services on Table 8A, do I have to report case managers on Table 5?

If a health center reports costs for case management services, one would expect to see case managers reported on Table 5, unless the service was contracted with no personnel time specifically identified. Similarly, if there are personnel on Table 5, one would expect costs on Table 8A unless personnel are volunteers. Some services DO NOT involve personnel. Spending funds on bus tokens, for example, would involve transportation costs on Table 8A, but no personnel on Table 5.

7. How are contracted personnel and their activities reported on Table 5?

If the contracted personnel are paid based on time worked (for example, one day per week), report the FTE on Table 5, Column A, and report the visits and patients receiving services from this provider. (See Appendix B for a more complete discussion of calculating the FTE of these providers.) If the contracted personnel are paid on a fee-for-service basis, DO NOT report FTE on Table 5, Column A, but report the visits and patients. This may require additional explanation in your UDS Report to clarify why visits and patients are reported, but no FTE.

8. How should activity be reported on Table 5 for behavioral health providers who provide both mental health and substance use disorder services?

Some health centers have integrated the positions of mental health provider and substance use disorder provider into a single position, which they call a behavioral health provider. In this instance, the health center has two choices. The first is to assert that substance use disorder problems are mental health problems and classify its behavioral health personnel as mental health personnel on Lines 20a, 20a1, 20a2, 20b, or 20c. Another method is to carefully record the time and activities of these dual function providers. In this case, identify each visit as either a mental health visit or a substance use disorder visit so the patients and visits can be correctly classified. In addition, keep track of providers' time so that FTEs on Table 5 (and associated costs on Table 8A) can be accurately allocated and recorded to the appropriate line.

9. If a psychiatric NP provides mental health and substance use disorder services to the same patient during a visit, how should we count this?

Report the visit under mental health in the main part of Table 5. DO NOT count the visits as one of each type. In the addendum, separately report the substance use disorder service provided by the mental health personnel during the visits. Classify the provider and costs (on Table 8A) as mental health.

10. Do I count the time of volunteer providers, interns, or residents?

Yes. Volunteers, interns, and residents are licensed practitioners, and their time is counted like that of any other practitioner. Note, however, that some may work shorter days because they are in educational sessions, may have more vacation time or other time off than other practitioners, or, in the case of volunteers, DO NOT have vacations or holidays. This would make them less than full-time. See the more complete discussion of counting volunteers, interns, and residents in Appendix B.

11. We contract with many licensed physicians to read our test results: an ophthalmologist reads the retinal photos that our medical assistant takes, a radiologist over-reads the X-rays that our X-ray tech takes, the outside laboratory's pathologist provides the test results from their machines, and a consulting cardiologist confirms findings of our electrocardiograms (EKGs). Should we report them as personnel, and do we report what they do as visits?

Report the costs for tests on Table 8A.

DO NOT report these activities, which are important to the provision of comprehensive care to patients, as visits.

Tests are **NOT** counted as visits anywhere in the UDS.

DO NOT report the time (FTE) of any individual who is working on a contract basis when the payment is not for their time worked but, rather, for the activity that they perform.

Under some circumstances, the EHBs may identify a system edit (costs with no personnel) that you will need to explain.

12. Where do we report community health workers that we employ?

Report personnel with responsibility as community health workers on Line 27c, as described in the Enabling Services section. If, however, you are using this term to describe someone who is performing the tasks normally associated with a medical assistant, an outreach worker, or another job title, count them in the corresponding category.

13. Where do we report medical providers whose only activity at a visit is providing MOUD?

MOUD provided by a medical provider is to be counted as medical. Report this activity on the line of the credentialed personnel providing this treatment (physicians are counted in medical [Lines 1–8], even if they only provide substance use disorder services at the visit). Additionally, report the activity in the substance use disorder section of the addendum (physicians are counted on Line 21a of the addendum).

DO NOT count them on the substance use disorder line of the main part of Table 5.

14. How do I count participants in a group session?

Only group treatment sessions for substance use disorders, mental health, or behavioral health may be counted. The visit must be recorded in each participant's chart. Each patient charted in a group session must be billed and the service must be paid consistent with health center policy by either the patient, insurance, or another contract maintained by the health center. If some patients or visits are billed and others are not, count only those that are billed. If other people are included in a behavioral health session but are not independently billed or charted, DO NOT count them as having a visit.

DO NOT count a group encounter with a patient that is not recorded in a patient health record. DO NOT report any group medical visits or group health education visits. Although in some instances they may be billable, the UDS specifically does not count these as visits.

15. Are virtual/telemedicine visits only permitted after a clinic (in-person) visit at the health center?

No, although virtual visits may occur after a clinic (in-person) visit. If the first or only visit is a countable virtual visit, the health center must register the patient and collect and report all relevant demographic, service, clinical, and financial data on the UDS tables.

16. Should the total number of patients reported on Table 3A be equal to the sum of the several types of service patients on the main part of Table 5?

Not unless you provide only one type of service to a patient. On Table 5, report patients for each type of service received. For example, count a patient who receives both medical and dental services once as a medical patient on Line 15 and once as a dental patient on Line 19.

17. Should a patient who received only a medication refill for a mental health condition be counted on the addendum of Table 5?

No. If medication refills were the only services provided, the service will NOT be considered a visit, and the patient and service will NOT be counted on the main part of Table 5 or the addendum to Table 5. Only count services that fully meet the countable visit definition.

The addendum is intended to capture treatment services for mental health (by medical providers) and substance use (by medical and mental health providers). DO NOT include services that only provide mental health or substance use disorder screenings, medication delivery or refills, patient education, referral, or case management.

18. Which provider types and what activity are included in the addendum?

Medical providers who provide mental health or substance use treatment are included in the addendum. Mental health providers who provide substance use treatment are also included in the addendum. Examples of provider activity reported in the addendum include:

- A physician who sees a patient for treatment of depression.
- An NP who is seeing a patient for diabetes and who is also treating them for signs of anxiety.
- A PA providing MOUD services to a patient with opioid use disorder.
- A licensed clinical psychologist seeing a patient for mental health problems and exacerbated substance use disorder.

TABLE 5: STAFFING AND UTILIZATION

Calendar Year: January 1, 2024, through December 31, 2024

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians				<cell not reported>
2	General Practitioners				<cell not reported>
3	Internists				<cell not reported>
4	Obstetrician/Gynecologists				<cell not reported>
5	Pediatricians				<cell not reported>
7	Other Specialty Physicians				<cell not reported>
8	**Total Physicians** (Lines 1–7)				<cell not reported>
9a	Nurse Practitioners				<cell not reported>
9b	Physician Assistants				<cell not reported>
10	Certified Nurse Midwives				<cell not reported>
10a	**Total NPs, PAs, and CNMs** (Lines 9a–10)				<cell not reported>
11	Nurses				<cell not reported>
12	Other Medical Personnel		<cell not reported>	<cell not reported>	<cell not reported>
13	Laboratory Personnel		<cell not reported>	<cell not reported>	<cell not reported>
14	X-ray Personnel		<cell not reported>	<cell not reported>	<cell not reported>
15	**Total Medical Care Services** (Lines 8 + 10a–14)				
16	Dentists				<cell not reported>
17	Dental Hygienists				<cell not reported>
17a	Dental Therapists				<cell not reported>
18	Other Dental Personnel		<cell not reported>	<cell not reported>	<cell not reported>
19	**Total Dental Services** (Lines 16–18)				
20a	Psychiatrists				<cell not reported>
20a1	Licensed Clinical Psychologists				<cell not reported>
20a2	Licensed Clinical Social Workers				<cell not reported>
20b	Other Licensed Mental Health Providers				<cell not reported>
20c	Other Mental Health Personnel				<cell not reported>
20	**Total Mental Health Services** (Lines 20a–c)				
21	**Substance Use Disorder Services**				
22	**Other Professional Services** (specify___)				

TABLE 5: STAFFING AND UTILIZATION (CONTINUED)

Calendar Year: January 1, 2024, through December 31, 2024

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists				<cell not reported>
22b	Optometrists				<cell not reported>
22c	Other Vision Care Personnel		<cell not reported>	<cell not reported>	<cell not reported>
22d	**Total Vision Services** (Lines 22a–c)				
23a	Pharmacists		<cell not reported>	<cell not reported>	<cell not reported>
23b	Clinical Pharmacists		<cell not reported>	<cell not reported>	<cell not reported>
23c	Pharmacy Technicians		<cell not reported>	<cell not reported>	<cell not reported>
23d	Other Pharmacy Personnel		<cell not reported>	<cell not reported>	<cell not reported>
23	**Pharmacy Personnel** (Lines 23a–d)		<cell not reported>	<cell not reported>	<cell not reported>
24	Case Managers				<cell not reported>
25	Health Education Specialists				<cell not reported>
26	Outreach Workers		<cell not reported>	<cell not reported>	<cell not reported>
27	Transportation Personnel		<cell not reported>	<cell not reported>	<cell not reported>
27a	Eligibility Assistance Workers		<cell not reported>	<cell not reported>	<cell not reported>
27b	Interpretation Personnel		<cell not reported>	<cell not reported>	<cell not reported>
27c	Community Health Workers		<cell not reported>	<cell not reported>	<cell not reported>
28	Other Enabling Services (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29	**Total Enabling Services** (Lines 24–28)				
29a	**Other Programs and Services** (specify___)		<cell not reported>	<cell not reported>	<cell not reported>
29b	**Quality Improvement Personnel**		<cell not reported>	<cell not reported>	<cell not reported>
30a	Management and Support Personnel		<cell not reported>	<cell not reported>	<cell not reported>
30b	Fiscal and Billing Personnel		<cell not reported>	<cell not reported>	<cell not reported>
30c	IT Personnel		<cell not reported>	<cell not reported>	<cell not reported>
31	Facility Personnel		<cell not reported>	<cell not reported>	<cell not reported>
32	Patient Support Personnel		<cell not reported>	<cell not reported>	<cell not reported>
33	**Total Facility and Non-Clinical Support Personnel** (Lines 30a–32)		<cell not reported>	<cell not reported>	<cell not reported>
34	**Grand Total** (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)				<cell not reported>

TABLE 5: SELECTED SERVICE DETAIL ADDENDUM

Calendar Year: January 1, 2024, through December 31, 2024

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)				
20a02	Nurse Practitioners				
20a03	Physician Assistants				
20a04	Certified Nurse Midwives				
Line	**Personnel by Major Service Category: Substance Use Disorder Detail**	**Personnel (a1)**	**Clinic Visits (b)**	**Virtual Visits (b2)**	**Patients (c)**
21a	Physicians (other than Psychiatrists)				
21b	Nurse Practitioners (Medical)				
21c	Physician Assistants				
21d	Certified Nurse Midwives				
21e	Psychiatrists				
21f	Licensed Clinical Psychologists				
21g	Licensed Clinical Social Workers				
21h	Other Licensed Mental Health Providers				

Table 5 and Addendum Cross-Table Considerations:

- Total patients on Table 5, Column C, should be greater than the total number of patients on Table 3A (unless only one type of service is offered at the health center or patients receive only one kind of service).
- Patients with medical visits on Table 5 are generally eligible for inclusion in eCQMs reported on Tables 6B and 7.
- The personnel on Table 5 is routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.
- Billable visits reported on Table 5 should relate to patient charges reported on Table 9D.
- If you submit Grant Reports, the total number of patients and visits reported on the grant table must be less than or equal to the corresponding number on the Universal Report for each cell.
- Table 6A activity reported for substance use disorder and mental health treatment are compared to the Table 5 addendum and the main part of Table 5 mental health and substance use lines.
- Visits and patients reported on the Table 5 Selected Service Detail Addendum must also be included in the main part of Table 5, medical plus mental health lines.

Instructions for Table 6A: Selected Diagnoses and Services Rendered

This table collects data on selected diagnoses and selected services rendered to health center patients. The data source for this table is your billing system, lab reports, and/or other information captured in your health IT systems or EHRs.

Table 6A does not reflect the full range of diagnoses and services rendered by a health center. The selected diagnoses and services represent those that are prevalent among Health Center Program patients, have been regarded as sentinel indicators of access to primary care, and/or are of special interest to HRSA.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

Several notable changes have been made to Table 6A, as outlined below:

- Some diagnosis and service codes have been updated. All changes are included in the table and outlined in the "Table 6A Code Changes" file found on the UDS Clinical Care resources webpage.
- In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.
- UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[15] websites.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

SELECTED DIAGNOSES, LINES 1–20F

Lines 1 through 20f present the name and applicable ICD-10-CM and value set codes for the diagnosis or diagnostic range/group. Wherever possible, diagnoses have been grouped into code ranges.

- Report all visits (both clinic [in-person] and virtual) and patients where the provider-assigned diagnostic code is included in the range/group of ICD-10-CM and value set codes shown in the given line.
- Report only diagnoses that were determined as part of documented, countable visits with licensed or credentialed medical, dental, mental health, substance use disorder, or vision providers.
- Report all diagnoses **rendered** at a specific visit. However, DO NOT count "active diagnoses" present at the time of a visit or laboratory test result, but not addressed during the visit.
- Use age at time of visit for diagnoses with specified age ranges.
- DO NOT report a diagnosis made by another professional or enabling service provider.
- DO NOT report a diagnosis when it is on the problem list but not diagnosed or treated during the visit.

[15] Login credentials are required. Users may request access through the Health Center Program Community.

Selected Diagnoses Visits and Patients, Columns A and B

Column A, Number of Visits by Diagnosis Regardless of Primacy

- Report the total number of visits (clinic [in-person] and virtual) during the calendar year where the indicated diagnosis, regardless of primacy, is diagnosed or treated and listed in the health IT/EHR or visit/billing record.
- Report on Lines 1 through 20f each included diagnosis made at a visit, regardless of the number of diagnoses listed for the visit. For example, count a patient visit with a diagnosis of hypertension and a diagnosis of diabetes once on Line 9 and once on Line 11.

Column B, Number of Patients with Diagnosis

- Report each patient who had one or more visits (clinic [in-person] and/or virtual) during the calendar year that were reported in the corresponding cell in Column A.
- Report a patient **only once** on any given line, regardless of the number of visits made for that specific diagnosis or family of diagnoses. For example, if a patient received treatment at a single visit for both anxiety disorder and obsessive-compulsive disorder, they will be counted once on Line 20b, Anxiety Disorders.

SELECTED TESTS/SCREENINGS, LINES 21–26E

Lines 21 through 26e present the name and applicable ICD-10-CM diagnostic, HCPCS, CPT procedure codes, and/or value sets for selected tests, screenings, and preventive services. For each line, report visits that are associated with a qualifying code from any of these code systems, but do not double-count any given visit (even if it includes, for example, a qualifying CPT code *and* a qualifying ICD-10-CM code).

- Report all tests, screenings, or procedures meeting the selection criteria that are provided to a health center patient anytime during the year. Only count these services if provided to patients who had one or more countable visits during the year.
- Only report tests, screenings, or procedures (e.g., mammograms, X-rays, tomography) that are:
  - performed by the health center; or
  - not performed by the health center, but paid for by the health center; or
  - not performed by the health center or paid for by the health center, but for which results are returned to a provider at the health center provider to follow up with the patient based on the results.
- During a visit with the provider, selected screenings or tests may be ordered. Report only completed services (NOT orders) in this section even if they were done at a later date.
- Use age at time of visit for diagnoses and tests with specified age ranges indicated.

Note: ICD-10-CM codes for some services (such as mammography and Pap tests) are listed to ensure capture of procedures that are done by the health center but may be coded with a different CPT code for state reimbursement under Title X or BCCEDP. In some instances, payers (especially governmental payers) and labs ask health centers to use different codes for services. In these instances, health centers should internally map these codes to the specified list for reporting purposes.

Note: Pre-Exposure Prophylaxis (PrEP), Line 21e, prescribed to patients for the purposes of preventing HIV, is to be limited to patients with an active prescription of PrEP based on a patient's risk for HIV exposure AND limited to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/tenofovir alafenamide (FTC/TAF) or cabotegravir for the purposes of preventing HIV, using ICD-10-CM code Z29.81.

Selected Tests/Screenings Visits and Patients, Columns A and B

Column A, Number of Visits

- Report the total number of visits (clinic [in-person] and/or virtual) for which one or more of the listed diagnostic tests, screenings, and/or preventive services were provided during the year. Services may have been provided at the time of a visit, before a visit, or after a visit.
- Codes for these services may be diagnostic (ICD-10-CM) codes or procedure (CPT or HCPCS) codes or value sets.
- During a single visit, more than one test, screening, or preventive service may be provided. Report each on the applicable line. If they are on the same line, report only one visit.

Column B, Number of Patients

- Report patients who had one or more visits (clinic [in-person] and/or virtual) during the calendar year for which one or more of the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21–26e were provided.
- Report patients who received more than one type of service during a single visit on each applicable line. For example, if a patient had a Pap test and contraceptive management during the same visit, this patient would be counted on both Lines 23 and 25.
- Report a patient **only once** per service, regardless of the number of times a patient receives a given service. For example, an infant who has an immunization at each of several well-child visits in the year has each visit reported in Column A but is counted only once in Column B.

Note: Include follow-up services related to a countable visit. For example, if a provider asks that a patient return in 30 days for a flu shot, when that patient presents, the shot is counted because it is legally considered to be a part of the initial visit. DO NOT report a service for an individual who is not a health center patient who comes in just for a flu shot during a health center–run flu clinic and without a specific referral from a prior visit.

DENTAL SERVICES, LINES 27–34

Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure and CPT codes for selected dental services. These services (with the exception of fluoride treatment, which may also be provided by medical providers) may be performed only by a dental provider who is reported on Lines 16–17a on Table 5 or by an in-scope dental contractor paid by the health center. Wherever appropriate, services have been grouped into code ranges. For these lines, the concept of a "primary" code is neither relevant nor used. All services are reported.

Dental Services Visits and Patients, Columns A and B

Column A, Number of Visits

- Report the total number of visits (clinic [in-person] and/or virtual) for which one or more of the listed diagnostic tests, screenings, and/or dental services were provided during the year. Services may be at the time of a visit, before a visit, or after a visit.
- During one visit, more than one test, screening, or dental service may be provided. Report each procedure, screening, or test on each separate, applicable line. If they are on the same line, report only one visit. For example, if a patient had more than one tooth filled during a visit, report only one visit for restorative services (Line 32), NOT one visit per tooth.

Column B, Number of Patients

- Report patients who had at least one visit with a dental professional during the calendar year for each of the selected dental services listed.
- Only report services that are provided at or as follow-up to countable visits (e.g., a comprehensive oral exam).
- Report a patient who had multiple types of services on each line, as appropriate. For example, a patient who had two teeth repaired and sealants applied during a single visit is reported once on Line 30 and once on Line 32.
- DO NOT report services provided by personnel other than licensed dentists, dental hygienists, dental therapists, or personnel working under their direct supervision, unless the service is fluoride treatment provided at a medical visit.
- DO NOT report fluoride treatments or varnishes that are applied outside of a comprehensive treatment plan, including when provided as part of a community service at schools, on this table or as a visit on Table 5.

SERVICES PROVIDED BY MULTIPLE ENTITIES

Be particularly careful when multiple entities are involved with a service. Use the following rules and general examples to guide reporting:

- Report the service if a health center provider orders and performs the service. For example, count a rapid HbA1c test ordered by a health center provider and performed in the health center lab.
- If the health center provider orders a test (e.g., HIV test) and the sample is collected at the health center and then sent to a reference lab for processing, report the test regardless of whether the test is paid for by the patient, the patient's insurance company,[16] a government entity, or the health center.
- Report a test when the health center provider asks a patient to get that test from a third party and the health center provider receives and reviews the test results with the patient, regardless of who pays for the service. For example, report mammograms performed by a third-party provider that a health center contracts with and for which the health center reviews the result with the patient.
- DO NOT report vaccinations performed by a health department when patients are referred to a city or county health department and the health center does not pay for the service, including referrals where a third party (e.g., the patient's insurance company) will make the payment.
- DO NOT report a test or service that a provider asks the patient to get from a third-party provider (e.g., an HIV test referred to a Ryan White program) that **does not bill the health center**, including referrals where a third party (e.g., the patient's insurance company) will make the payment if the test or service results are reviewed and acted on by the third-party provider. For example, DO NOT count mammograms performed by the county health department for which the county will follow up with the patient directly and the health center did not pay for the service. (These are generally noted in Column III: Formal Written Referral Arrangement [Health center DOES NOT pay] of Form 5A: Services Provided).

FAQ FOR TABLE 6A

1. If a case manager or health educator serves a patient who, for example, has diabetes, we often report that diagnostic code for the visit. Should we report this on Table 6A?

[16] Billing rules require that the charge for a lab test ordered by a provider be sent directly to a third party (including Medicaid and Medicare) and not to the provider or the health center.

No. Report on Table 6A only visits with medical, dental, mental health, substance use disorder, and vision providers who are diagnosing and treating within their own field.

2. The instructions for this table call for diagnoses and services at visits. If we provide the service but it is not counted as a visit (such as an immunization given at a health fair), should it be reported on this table?

Report the visit if a service is provided because of a prescription or plan from an earlier counted visit, such as if a provider asks a patient to come back in four months for a mammogram.

DO NOT report services given at health fairs to an individual who is not a health center patient, regardless of who provides the service or the level of documentation that is done, such as an HIV test at a health fair.

3. Some diagnostic and/or procedure codes in our system are different from the codes listed. What do we do?

It is possible that information for Table 6A is not available using the codes shown because of idiosyncrasies in state or clinic billing systems. Generally, these involve situations where (a) the state uses unique billing codes other than the normal CPT code for state billing purposes (e.g., EPSDT) or (b) internal or state confidentiality rules mask certain diagnostic data. The following table provides examples of problems and solutions:

Line	Problem	Potential Solution
1	HIV diagnoses are kept confidential, and alternative diagnostic codes are used.	Include the alternative codes used at your center on these lines as well.
23	Pap tests are charged to a state BCCEDP using a special code.	Add these special codes to the other codes listed.
26	Well-child visits are charged to the state EPSDT program using a special code (often starting with W, X, Y, or Z).	Add these special codes to the other codes listed and count all such visits. DO NOT count EPSDT follow-up visits in this category.

4. The instructions specifically say that the source of information for Table 6A is "billing systems or health ITs." There are some services for which we DO NOT bill and/or for which there are no visits in our system. What do we do?

Although health centers are only required to report data derived from billing systems or health ITs, the reported data may understate services in the circumstances described below. In today's health ITs/EHRs, diagnoses and/or services should be captured in one of the templates available. To more accurately reflect the level of service, use other codes in the system to enable the tracking.

DO NOT report referrals for which you DO NOT pay or evaluate results and provide back to the patient (e.g., sending patients to the county health department for mammograms).

Line	Problem	Potential Solution
21	HIV test samples are collected by us but processed and paid for by the state and DO NOT show on the visit form or in the billing system.	• Preferred: Use the correct code, but report a zero charge. • Alternative: Use documented completed lab results returned to the health center.
Multiple	Tests (HIV tests, Pap tests, etc.) are ordered and samples collected by us. We send samples to a reference lab for processing, but the lab bills Medicaid or Medicare directly.	• Preferred: Use the correct code, but report a zero charge. • Alternative: Use documented completed lab results returned to the health center.

Line	Problem	Potential Solution
22	Mammograms are paid for by us but are conducted by a contractor and DO NOT show in the billing system for individual patients.	• Preferred: Use the correct code, with associated charge. • Alternative: Use the bills from the independent contractor to identify the mammograms conducted and the patients who received them and report these numbers.
23	Pap tests are processed and paid for by the state and DO NOT show on the visit form or in the billing system.	• Preferred: Use the correct code, but report a zero charge. • Alternative: Use documented completed lab results returned to the health center.
24	Flu shots and other vaccinations are NOT counted because the vaccines are obtained at no cost to the health center.	• Preferred: Use the correct code, but report a zero charge.
25	Contraceptive management is funded under Title X or a state family planning program and does not have a Z30- diagnosis attached to it.	• Preferred: Add a "dummy code" you can map to the Z30- code. • Alternative: Code with both the Z30- and the state-mandated code, but suppress printing of the Z30- code. Take care not to count the same visit twice.

5. **Are we required to report all diagnoses and services rendered during a visit?**
   Yes and no. No, because there are many diagnoses that may be used but not collected on Table 6A. Yes, because documentation and reporting of all diagnoses (not just primary diagnosis) and services rendered during all UDS countable visits are required. It is important that you appropriately document the breadth of comprehensive services delivered during each visit, including behavioral health services provided during a medical visit (e.g., Screening, Brief Intervention, and Referral to Treatment [SBIRT] and/or treatment and counseling for mental health and substance use disorders).

6. **What happens if the CPT, HCPCS, or ICD-10-CM codes change again?**
   The codes are reviewed and updated annually by the UDS Support Center personnel. If you think a CPT, ICD, HCPCS, or ADA code for a measure is not reflected in the list or has changed, contact the UDS Support Center at **1-866-UDS HELP**, udshelp330@bphcdata.net, or BPHC Contact Form. Personnel will review the code(s) with HRSA's BPHC and incorporate approved changes to codes in the manual for future reporting.

7. **Are there ICD-10-CM codes for PrEP management?**
   It is critical that health centers limit the reporting of Line 21e to patients **prescribed PrEP based on a patient's risk for HIV exposure AND** limited to emtricitabine/tenofovir disoproxil fumarate (FTC/TDF) or emtricitabine/tenofovir alafenamide (FTC/TAF) or cabotegravir for the purposes of **preventing** HIV. Effective October 1, 2023, ICD-10-CM code Z29.81 became effective. This code should be used to identify PrEP management for health center patients. Health centers can cross check their counts with America's HIV Epidemic Analysis Dashboard, which provides state- and territory-level counts of individuals prescribed PrEP.

8. **Should suspected, possible, probable, or inconclusive SARS-CoV-2 (novel coronavirus) disease screening and/or tests be reported as diagnosed?**

   No. If the provider documents "suspected," "possible," "probable," or "inconclusive" coronavirus (SARS-CoV-2) disease, DO NOT assign code U07.1 **and** DO NOT report the patient as having this diagnosis. Only report confirmed novel coronavirus cases.

9. **If a patient presents to the health center with pneumonia or other health conditions caused by coronavirus (SARS-CoV-2) disease, is the other health condition reported on Table 6A?**

Assign code U07.1 **and** the appropriate ICD-10 code associated with the other health condition. Documentation in the patient's health record and reporting of all diagnoses (not just primary diagnosis) and services rendered during the visit are required, if applicable. For example, if a patient has pneumonia confirmed due to coronavirus (SARS-CoV-2) disease, assign and report codes U07.1 (coronavirus disease) on Line 4c and J12.89 (other viral pneumonia) on Line 6a.

10. We DO NOT perform some services and tests and refer these out. Can we count these?

Possibly. If you perform the service, or if you DO NOT perform the service or test but paid another provider to provide the requested service, or if the results are returned to the health center provider to evaluate and provide results back to the patient, you may report these services. The following examples illustrate these rules:

- Report a Pap test specimen collected by the health center but read by an outside pathologist who then bills a third party.
- Report a blood draw performed by the health center and sent to an outside lab who then bills Medicaid and sends the results back to the health center.
- DO NOT report the referral of a patient to the local hospital or county health department for a mammogram where the local hospital or county health department providers perform the test and provide results directly to the patient.

11. Can we count patients on multiple lines if they had more than one type of service at a visit?

If patients receive multiple services at one visit and the services are reflected on this table, you should report the patient and visit once on each applicable line. The following examples illustrate these rules:

- Report a patient with hypertension who also receives an HIV test on Line 11 (hypertension) and on Line 21 (HIV test).
- If both an HIV test and a Pap test were provided during a visit, then report a visit on both Line 21 (HIV test) and Line 23 (Pap test).
- If a patient receives multiple immunizations at one visit, report only one visit on Line 24.
- Report a patient who comes in for an annual physical and a flu shot. Report this patient on Line 24a (flu shot) but not on any diagnostic line (since annual physical is not collected on this table).

12. Can we count patients as having received alcohol- or substance use–related SBIRT when only some components are complete?

To count the patient as having received SBIRT (Line 26b), the patient must have received screening **and** brief intervention **OR** screening, brief intervention, **and** referral to treatment.

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED

Calendar Year: January 1, 2024, through December 31, 2024

SELECTED DIAGNOSES

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
	Selected Infectious and Parasitic Diseases			
1–2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21 **OID**: 2.16.840.1.113883.3.464.1003.120.12.1003		
3	Tuberculosis	A15- through A19-, O98.0-, Z86.15, Z22.7 **OID**: 2.16.840.1.113762.1.4.1146.451		
4	Sexually transmitted infections (gonococcal infections and venereal diseases)	A50- through A64-, A69.0, A69.1, A69.8, A69.9 **OID**: 2.16.840.1.113883.3.464.1003.112.11.1003		
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.1- **OID**: 2.16.840.1.113883.3.464.1003.110.12.1025		
4b	Hepatitis C	B17.1-, B18.2, B19.2- **OID**: 2.16.840.1.113762.1.4.1146.153		
4c	Novel coronavirus (SARS-CoV-2) disease	U07.1 **OID**: 2.16.840.1.113762.1.4.1248.139, 2.16.840.1.113762.1.4.1200.151		
4d	Long COVID	U09.9 **OID**: 2.16.840.1.113762.1.4.1222.1391		
	Selected Diseases of the Respiratory System			
5	Asthma	J45- **OID**: 2.16.840.1.113883.3.526.3.362		
6	Chronic lower respiratory diseases	J40 (count J40 only when code U07.1 **is not** present), J41- through J44-, J47-, J4A-		
6a	Acute respiratory illness due to novel coronavirus (SARS-CoV-2) disease	J12.82, J12.89, J20.8, J40, J22, J98.8, J80 (count codes listed only when code U07.1 **is** also present) **OID**: 2.16.840.1.113762.1.4.1029.374		
	Selected Other Medical Conditions			
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60- through N65-, R92-		
8	Abnormal cervical findings	C53-, C79.82, D06-, N87.0, N87.1, N87.9, R87.61- (exclude R87.615 and R87.616), R87.629, R87.810, R87.820		
9	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-) **OID**: 2.16.840.1.113762.1.4.1219.35		
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-, Q24-		

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
11	Hypertension	I10- through I16-, O10-, O11- **OID**: 2.16.840.1.113762.1.4.1222.1547 (includes all codes other than O11-)		
12	Contact dermatitis and other eczema	H01.13-, L20.89, L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-		
13	Dehydration	E86-		
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-, X30-, X31-, X32-		
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)		
	Selected Childhood Conditions (limited to ages 0 through 17)			
15	Otitis media and Eustachian tube disorders	H65- through H69-, H72-		
16	Selected perinatal/neonatal medical conditions	A33, P19-, P22- through P29- (exclude P29.3-), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), Q86-		
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3- (exclude R63.39)		
	Selected Mental Health Conditions, Substance Use Disorders, and Exploitations			
18	Alcohol-related disorders	F10-, G62.1, K70-, O99.31-		
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-		
19a	Tobacco use disorder	F17-, O99.33-, Z72.0		
20a	Depression and other mood disorders	F30- through F39-		
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F43.8-, F93.0		
20c	Attention deficit and disruptive behavior disorders	F90- through F91-		
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

Line	Diagnostic Category	Applicable ICD-10-CM Code or Value Set Object Identifier (OID)	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
20e	Human trafficking	T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42		
20f	Intimate partner violence	T74.11-, T74.21-, T74.31-, Z69.11		

SELECTED SERVICES RENDERED

Line	Service Category	Applicable ICD-10-CM, CPT-4/I/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
	Selected Diagnostic Tests/ Screening/Preventive Services			
21	HIV test	**CPT-4**: 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806		
21a	Hepatitis B test	**CPT-4**: 80074, 86704 through 86707, 87340, 87341, 87350, 87467, 87912		
21b	Hepatitis C test	**CPT-4**: 80074, 86803, 86804, 87520 through 87522, 87902		
21c	Novel coronavirus (SARS-CoV-2) diagnostic test	**CPT-4**: 87426, 87428, 87635, 87636, 87637, 87811 **HCPCS**: U0001, U0002, U0003, U0004, U0005 **CPT PLA**: 0202U, 0223U, 0225U, 0240U, 0241U		
21d	Novel coronavirus (SARS-CoV-2) antibody test	**ICD-10**: Z01.84 **CPT-4**: 86318, 86328, 86408, 86409, 86413, 86769 **CPT PLA**: 0224U, 0226U		
21e	Pre-Exposure Prophylaxis (PrEP)-associated management of **all** patients on PrEP	**ICD-10**: Z29.81		
22	Mammogram	**ICD-10**: Z12.31 **CPT-4**: 77062, 77063, 77065, 77066, 77067 **HCPCS:** G0279		
23	Pap test	**ICD-10**: R87.619, R87.629, Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419) **CPT-4**: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 **HCPCS:** G0123, G0143, G0144, G0145, G0147, G0148, P3000		
24	Selected immunizations: hepatitis A; haemophilus influenzae B (Hib); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); measles, mumps, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4**: 90632, 90633, 90634, 90636, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90671, 90677, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90720, 90721, 90723, 90730, 90731, 90732, 90739, 90740, 90743, 90744, 90745, 90746, 90747, 90748, 90759		

Line	Service Category	Applicable ICD-10-CM, CPT-4/I/PLA, or HCPCS Code	Number of Visits (a)	Number of Patients (b)
24a	Seasonal flu vaccine	**CPT-4**: 90630, 90653 through 90662, 90672, 90673, 90674, 90682, 90685 through 90688, 90694, 90724, 90756		
24b	Coronavirus (SARS-CoV-2) vaccine	**CPT-4**: 90480, 91304, 91318, 91319, 91320, 91321, 91322 Codes listed include those available as of the release date of this manual.		
25	Contraceptive management	**ICD-10**: Z30-		
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99381 through 99383, 99391 through 99393 **ICD-10**: Z00.1-, Z76.1. Z76.2		
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4**: 83655		
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4**: 99408, 99409 **HCPCS**: G0396, G0397, G0443, H0050		
26c	Smoke and tobacco use cessation counseling	**CPT-4**: 99406, 99407 **HCPCS**: S9075		
26d	Comprehensive and intermediate eye exams	**CPT-4**: 92002, 92004, 92012, 92014		
26e	Childhood development screenings and evaluations (limited to patients who are less than 18 years of age)	**CPT-4:** 96110, 96112, 96113, 96127 **ICD-10:** Z13.4-		

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
	Selected Dental Services			
27	Emergency services	**CDT:** D0140, D9110		
28	Oral exams	**CDT:** D0120, D0145, D0150, D0160, D0170, D0171, D0180		
29	Prophylaxis—adult or child	**CDT:** D1110, D1120		
30	Sealants	**CDT:** D1351		
31	Fluoride treatment—adult or child	**CDT:** D1206, D1208 **CPT-4:** 99188		
32	Restorative services	**CDT:** D21xx through D29xx		
33	Oral surgery (extractions and other surgical procedures)	**CDT:** D7xxx		
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**CDT:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx		

SOURCES OF CODES

Code System	Primary Source	Secondary Source
ICD-10-CM	National Center for Health Statistics (NCHS)	ICD10Data.com
CPT	American Medical Association (AMA)	CMS
Code on Dental Procedures and Nomenclature (CDT)	American Dental Association (ADA)	<blank>
CVX	CDC Vaccine Administered Code Set (CVX)	<blank>
HCPCS	CMS	HCPCSData.com
Value Sets	National Library of Medicine Value Set Authority Center	<blank>

Note: "X" in a code denotes any number, including the absence of a number in that place. **Dashes (-) in a code** indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect whether or not a code is billable. Instead, they are used to point out that other codes in the series are to be considered.

Table 6A Cross-Table Considerations:

- The count of patients by diagnosis reported on Table 6A will not be the same count as on Tables 6B and 7, due to differences in criteria that must be met for inclusion on Tables 6B or 7.
- If you submit Grant Reports, the total number of patients and visits reported on the grant table must be less than or equal to the corresponding number on the Universal Report for each cell.

Instructions for Tables 6B and 7

Tables 6B and 7 collect data on selected quality of care and clinical health outcome measures. HRSA's BPHC first implemented these measures in 2008 and continues to update them. HRSA's BPHC will continue to revise and expand these measures consistent with the National Quality Strategy, CMS electronic clinical quality measures (eCQMs), and other national quality initiatives.

The clinical quality measures (CQMs) described in this manual must be reported by all health centers using specifications detailed in the measure definitions described below. The majority of the UDS CQMs are aligned with CMS 2024 Performance Period Eligible Professional/Eligible Clinician eCQMs. Use the most current CMS-issued eCQM specifications for the eCQM number and version referenced in the UDS Manual for 2024 reporting and measurement period. Although there are other year and version updates available from CMS, they are **NOT to be used** for 2024 reporting.

Note: The phrase "measurement period" used in this section is intended to represent calendar year 2024 unless another timeframe is specifically noted.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

For UDS CQM reporting, evaluate and include patients seen during the year for a countable UDS visit on Table 5 **AND** who had a visit that meets the qualifying encounter definitions in the CQM criteria.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

Complete descriptions of the measure specifications can be found at the CMS Electronic Clinical Quality Improvement (eCQI) Resource Center. The eCQM measure numbers and links are provided to assist you, when applicable. Further clarification or interpretation of CMS eCQMs may be provided by the eCQM Flows and the measure steward (listed in Appendix H). The Measure Compare tool function available through the eCQM links compares two consecutive years of eCQM specifications and highlights changes. HRSA's BPHC defers to the guidance of the measure steward organization responsible for providing and maintaining the measure requirements and logic statements that describe the criteria for eCQM reporting. Additionally, the use of official versions of vocabulary value sets as contained in the Value Set Authority Center (VSAC)[17] is encouraged for health centers capable of appropriately using this resource as defined to support the data reporting of these CQMs.

Note: CMS uses logic statements describing the criteria for eCQM reporting using Clinical Quality Language (CQL) in an effort to standardize reporting workflows. Health centers are advised to review workflows and to work with their health IT/EHR vendors and IT personnel to ensure that required data are being captured correctly to calculate measures.

COLUMN LOGIC INSTRUCTIONS

Column A (A, 2A, or 3A): Number of Patients in the Denominator

- Report the total number of patients who fulfill the detailed criteria described for the specified measure.
- Report all patients meeting the criteria in the health center's denominator, including all sites (e.g., urgent care, prenatal), all in-scope programs (e.g., targeted programs, special populations), and all providers.
- Remove patients who meet exclusion or exception criteria from the denominator.

[17] Requires free user account and login.

Because the denominator for each measure is defined in whole or in part in terms of age (or age and sex), comparisons to the numbers on Tables 3A, 6B, and 7 will be made when evaluating your submission. The numbers in Column A of Tables 6B and 7 will NOT be equal to those that might be calculated on Table 3A for the following reasons:

(1) Table 3A measures age as of December 31 of the calendar year. Tables 6B and 7 measure stewards may define other time periods to measure age.

(2) Most of the measures have exclusion and exception criteria that exclude some patients from the assessment.

Although comparisons may be made between the numbers on Table 6A and Tables 6B and 7, the numbers in Column A of Tables 6B and 7 will NOT be equal to those reported in Column B of Table 6A for the following reasons:

(1) All patients, regardless of age, seen for all reportable services and diagnoses, are included on Table 6A, but Tables 6B and 7 relate only to patients of specific age ranges.

(2) Table 6A reflects diagnoses and services during the calendar year, but in Tables 6B and 7 measures may require patients to be considered based on active diagnoses or a look-back period of completed services.

(3) Codes utilized for metrics across the two tables may differ.

Typically, not all prenatal care patients will deliver during the calendar year. For this reason, birth outcomes on Table 7 are compared to prenatal care patients on Table 6B.

Column B (B, 2B, or 3B): Number of Records Reviewed

- Report the total number of health center patients from the denominator (Column A) for whom data have been reviewed. The number will essentially become the denominator in evaluating the numerator criteria and will be:
  - all patients who fit the criteria (the same number as the denominator reported in Column A), or
  - a number equal to or greater than 80%[18] of all patients who meet the criteria (a value no less than 80% of the denominator reported in Column A). See Appendix C for more information on reduced denominator reporting.

Records for new patients should be obtained from their former providers to document prior treatment, including data for look-back periods. Patient health records, including tests and procedures, obtained from other providers may be recorded in the health center's health IT/EHR system consistent with internal patient health records policies, at which point they may be used in the calculated performance rate for the applicable measure.

The number in Column B (records reviewed) must be no less than 80% of the number in Column A. The reduced total (in Column B) may not be the result of excluding patients based on a variable related to the measure (e.g., if patients from a pediatric service delivery site are missing from the health IT/EHR, this method cannot be used for the Childhood Immunization Status eCQM).

[18] To streamline the process for reporting on the CQMs, and to encourage the use of health IT to report on the full denominator of patients, health centers may use all of the records available in the health IT/EHR for any given clinical quality measure if at least 80% of all health center patients' health records are included in the health IT/EHR and the patients missing from the health IT/EHR are not related to any target group or variable involved with that given measure. For example, if the patients from a pediatric service delivery site are missing in the health IT/EHR, it cannot be used for the childhood immunization measure.

Column C (C or 2C) or 3F: Number of Charts/Records Meeting the Numerator Criteria

- Report the total number of records (included in the count for Column B) that meet the numerator criteria for the specified CQM. The number in Column C or F (records in the numerator) can never exceed the number in Column B (patient health records reviewed).
- Remove patients who meet exception criteria from the numerator and denominator.

Note: The percentage of patient health records meeting the numerator criteria can be calculated by dividing Column C or 3F by Column B.

Criteria vs. Exceptions and Exclusions in Health ITs/EHRs vs. Chart Reviews

In the information that follows, "conditions" or "criteria" are at times used interchangeably, as are "exceptions" or "exclusions." This is partly because of the differing language and procedures in a health IT/EHR-based report versus a chart audit report. In a health IT/EHR review, all criteria for a measure must be locatable in the health IT/EHR and must be in the health IT/EHR for each patient at the health center. If they cannot be found, findings will be distorted and the health IT/EHR cannot be used.

And vs. Or

In the measures described in this section, when reviewing the measure specifications, conditions linked with "and" mean that each of the conditions must be met. If some but not all conditions are met, the services for that patient are considered to have failed to meet the numerator criteria.

Conditions linked with "or" mean that criteria must be evaluated in the order prescribed by the measure specifications. For example, if the first statement is not met, move to the second, then the third, etc. If none of the conditions are met, the services for that patient are considered to have failed to meet the numerator criteria.

DETAILED INSTRUCTIONS FOR CLINICAL QUALITY MEASURES

The CQMs reported in the UDS relate to patients who had a countable visit. Report each measure using the criteria outlined below. Each measure has been organized in the same way to assist with data collection and reporting.

- **Measure Description:** The quantifiable indicator to be evaluated.
- **Denominator:** Patients who fit the detailed criteria described in the specific measure are to be included and evaluated.
- **Numerator:** Records (from the denominator) that meet the criteria for the specified measure.
- **Denominator Exclusions:** Patients not to be considered for the measure and who are removed from the denominator before determining if numerator criteria are met.
- **Denominator Exceptions:** Patients who meet denominator criteria but do not meet numerator criteria because they meet any of the exceptions listed for the measure and, therefore, are removed from the denominator.
- **Specification Guidance:** CMS measure guidance that assists with understanding and implementing eCQMs.
- **UDS Reporting Considerations:** Additional requirements and guidance from HRSA's BPHC that must be applied to the specific measure and that may differ from or expand on the eCQM specifications.

Instructions for Table 6B: Quality of Care Measures

The quality of care measures reported on Table 6B are "process measures."[19] This means they document services that have been shown to be correlated with and serve as a proxy for positive long-term health outcomes. Individuals who receive routine preventive care and timely chronic care are more likely to have positive outcomes.

The text directly below indicates changes from 2023 calendar year reporting to the 2024 calendar year reporting: Several notable changes have been made to Table 6B, as outlined below:

- The specifications for the reported clinical quality measures (CQMs) have been revised to align with the CMS eCQMs. The CQMs are aligned with the most current eCQMs for Eligible Professionals for the 2024 version number referenced in the UDS Manual for the measurement period. (Later version updates are available, but they should not be used for the 2024 reporting.)
- In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.
- UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[20] websites.
- The Tobacco Screening measure denominator age changed from patients aged 18 or older to those aged 12 or older.
- The Statin Therapy measure now includes:
  - Patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) (a change from the prior year, when only those with an active diagnosis of ASCVD were included).
  - Patients 40 through 75 years of age with a 10-year ASCVD risk score greater than or equal to 20 percent have been added to the denominator.
- The HIV Screening measure has added a denominator exception for patients who died on or before the end of the measurement period.
- The Depression Screening measure has removed the diagnosis of depression as a denominator exclusion.
- The Depression Remission measure no longer excludes permanent nursing home residents from the denominator.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

[19] The Depression Remission measure is an outcome measure.
[20] Login credentials are required. Users may request access through the Health Center Program Community.

TABLE 6B: QUALITY OF CARE MEASURES – INSTRUCTIONS

This table specifically includes the following CQMs:

Screening and Preventive Care	Maternal Care and Children's Health	Disease Management
• Cervical Cancer Screening • Breast Cancer Screening • Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan • Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention • Colorectal Cancer Screening • HIV Screening • Preventive Care and Screening: Screening for Depression and Follow-Up Plan	• Early Entry into Prenatal Care • Childhood Immunization Status • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Dental Sealants for Children between 6–9 Years	• Statin Therapy for the Prevention and Treatment of Cardiovascular Disease • Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet • HIV Linkage to Care • Depression Remission at Twelve Months

SECTIONS A AND B: DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

This section includes information about patients in the prenatal care program.

- Report on all patients who are either provided direct prenatal care or referred for prenatal care.
- Report on the age and trimester of entry into prenatal care for all prenatal care patients, regardless of whether they receive all or some of their prenatal services in the health center or are referred elsewhere.
- DO NOT include patients who had a positive pregnancy test but did not initiate prenatal care with the health center or its referral network.
- DO NOT include patients who did not receive prenatal care from a health center provider or who were not referred by the health center to another provider for prenatal care.
- DO NOT include patients who chose to receive all their prenatal care outside of the health center's referral network.
- DO NOT include pregnant women who received care unrelated to their pregnancy and who are being seen elsewhere for prenatal care.

Prenatal Care by Referral Only (check box)

All health centers are required to provide prenatal care to patients, either directly or by referral.

- Check the "Prenatal Care by Referral Only" box if you provide prenatal care to patients **only** through direct formal written referral to another provider (such as a memorandum of understanding or memorandum of agreement), as described on Form 5A, Columns II and III.
- DO NOT check this box if your health center providers provide some or all prenatal care to patients directly.

Section A: Age of Prenatal Care Patients (Lines 1–6)

- Report the total number of patients by age group who received prenatal care during the calendar year from the health center or from a provider in your referral network. Include all patients receiving any prenatal care, including the delivery of their child, during the calendar year, regardless of when that care was initiated.
- Include patients who:
  - receive all their prenatal care from the health center,
  - were referred by the health center to another provider for all their prenatal care,
  - began prenatal care with another provider but transferred to the health center at some point during their prenatal care,
  - began prenatal care with the health center but were transferred to another provider at some point during their prenatal care,
  - were provided with all their prenatal care by a health center provider but were delivered by another provider,
  - began or were referred for care during the previous calendar year or in this calendar year and delivered during the calendar year, or
  - began or were referred for their care in this calendar year but will not or did not deliver until the next year.
- To determine the appropriate age group, use the patient's age on December 31 of the calendar year.

Note: As many as half of all prenatal care patients reported will usually have been reported in the prior year or will be reported in the next year.

Section B: Early Entry into Prenatal Care (Lines 7–9), No eCQM

Measure Description

Percentage of prenatal care patients who entered prenatal care during their first trimester.

Calculate as follows:

Denominator: Line 7 + Line 8 + Line 9, Columns A + B

- Patients seen for prenatal care during the year

Numerator: Line 7, Columns A + B

- Patients who began prenatal care at the health center or with a referral provider (Column A), or who began care with another prenatal provider (Column B), during their first trimester

Exclusions/Exceptions

- Denominator Exclusions
  - Not applicable
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report on Lines 7–9 all patients who received prenatal care, either directly or through a referral, including but not limited to the delivery of a baby during the calendar year.
    - **First Trimester (Line 7):** Report patients who were prenatal care patients during the measurement period and whose first visit occurred when they were estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period.
    - **Second Trimester (Line 8):** Report patients who were prenatal care patients during the measurement period whose first visit occurred when they were estimated to be between the start of the 14th week and the end of the 27th week after the first day of their last menstrual period.
    - **Third Trimester (Line 9):** Report patients who were prenatal care patients during the measurement period and whose first visit occurred when they were estimated to be 28 weeks or more after the first day of their last menstrual period.

Note: It is unusual for the number in Column B to be very large or larger than that in Column A. This is especially true for the third trimester, because it would require patients to have begun care very late and then transfer to the health center in a very short period of time.

The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of patients who received some or all of their prenatal care from the health center during the calendar year and is equal to the number reported on Line 6.

- Use the following criteria to identify how prenatal care patients are reported:
    - Only report patients who had their first comprehensive prenatal exam with the health center or with the referral provider as having begun prenatal care. Health center visits that include pregnancy and other lab tests, dispensing vitamins, taking a health history, and/or obtaining a nutritional or psychosocial assessment only DO NOT count as the start of prenatal care.
    - Determine the trimester by the trimester of pregnancy that the patient was in when they began prenatal care either at one of the health center's service delivery locations or with another provider, including a referral provider.
    - Report a patient who begins prenatal care with the health center or is referred by the health center to another provider only once in Column A (NOT in Column B).
    - Report a patient who begins prenatal care on their own with another provider and then transfers to the health center only once in Column B (NOT in Column A).
    - Patient self-report of trimester of entry is permitted.
    - Report the patient twice as a prenatal care patient in those rare instances when a patient receives prenatal care services for two separate pregnancies in the same calendar year.

SECTIONS C THROUGH M: OTHER QUALITY OF CARE MEASURES

- For each of the measures, specifically assess patients seen during the year for a UDS countable visit **AND** CQM qualifying encounter, as specified in the measure criteria (e.g., patients who had a visit reported on Table 5 at least once during the measurement period and who had a visit that meets the qualifying encounter specifications in a given measure).
- For each of these measures, calculate age using the specified dates as required for each eCQM.
- Patients seen only for care in an urgent care setting, patients seen only once for acute care, patients seen only for specialty care, and/or patients who have since left the practice are not to be excluded from the measures. Patients with a countable visit during the calendar year (reported anywhere on Table 5) and who meet the qualifying encounter criteria in the measure specifications are to be included.
- For measures requiring the completion of screenings, tests, or procedures to meet the numerator criteria, the findings of the screenings, test results, or procedures must be accessible in the patient health record.

Note: In this section, the term "measurement period" is the timeframe specified by the measure steward. For measures not electronically specified, the measurement period is calendar year 2024.

Childhood Immunization Status (Line 10), CMS117v12

Measure Description

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (Hib); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Calculate as follows:

Denominator: Columns A and B

- Children who turn 2 years of age during the measurement period and who had a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include patients who were 2 years of age at the end of the measurement period, reflective of children with birthdate on or after January 1, 2022, and birthdate on or before December 31, 2022.

Numerator: Column C

- **Diphtheria, tetanus, and pertussis (DTaP) vaccination**

  Children with any of the following on or before the child's second birthday meet the criteria:
  - At least four DTaP vaccinations, with different dates of service. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine.
  - Encephalitis due to the diphtheria, tetanus, or pertussis vaccine.
- **Poliovirus vaccination (IPV)**

  Children with either of the following on or before the child's second birthday meet the criteria:
  - At least three IPV vaccinations, with different dates of service. DO NOT count a vaccination administered prior to 42 days after birth.

- Anaphylaxis due to the IPV vaccine.

- **Measles, mumps, and rubella vaccination (MMR)**

  Children with any of the following meet the criteria:

  - At least one MMR vaccination on or between the child's first and second birthdays.
  - Anaphylaxis due to the MMR vaccine on or before the child's second birthday.
  - All of the following anytime on or before the child's second birthday (on the same or different date of service): history of measles, mumps, or rubella.

- **Haemophilus influenzae type b vaccination (Hib)**

  Children with either of the following meet the criteria on or before the child's second birthday:

  - At least three Hib vaccinations, with different dates of service. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the Hib vaccine.

- **Hepatitis B (Hep B)**

  Children with any of the following on or before the child's second birthday meet the criteria:

  - At least three hepatitis B vaccinations, with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the patient's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
  - Anaphylaxis due to the hepatitis B vaccine.
  - History of hepatitis B illness.

- **Varicella vaccination (VZV)**

  Children with any of the following meet the criteria:

  - At least one VZV vaccination, with a date of service on or between the child's first and second birthdays.
  - Anaphylaxis due to the VZV vaccine on or before the child's second birthday.
  - History of varicella zoster (e.g., chicken pox) illness on or before the child's second birthday.

- **Pneumococcal conjugate (PCV)**

  Children with either of the following on or before the child's second birthday meet the criteria:

  - At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the pneumococcal vaccine on or before the child's second birthday.

- **Hepatitis A (Hep A)**

  Children with any of the following meet the criteria:

  - At least one hepatitis A vaccination, with a date of service on or between the child's first and second birthdays.
  - Anaphylaxis due to the hepatitis A vaccine on or before the child's second birthday.
  - History of hepatitis A illness on or before the child's second birthday.

- **Rotavirus (RV)**

  Children with any of the following meet the criteria:

  - At least two doses of the two-dose rotavirus vaccine on different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - At least three doses of the three-dose rotavirus vaccine on different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine, all on different dates of service, on or before the child's second birthday. DO NOT count a vaccination administered prior to 42 days after birth.
  - Anaphylaxis due to the rotavirus vaccine on or before the child's second birthday.

- **Influenza (Flu)**

  Children with either of the following on or before their second birthday meet the criteria:

  - At least two influenza vaccinations, with different dates of service on or before the child's second birthday. DO NOT count a vaccination administered prior to 6 months (180 days) after birth.
    - One of the two vaccinations can be a live attenuated influenza vaccine (LAIV) vaccination (the nasal spray flu vaccine) administered on the child's second birthday. DO NOT count a LAIV vaccination administered before the child's second birthday.
  - Anaphylaxis due to the influenza vaccine.

Exclusions/Exceptions

- Denominator Exclusions
  - Children with any of the following on or before the child's second birthday:
    - Severe combined immunodeficiency
    - Immunodeficiency
    - HIV
    - Lymphoreticular cancer, multiple myeloma, or leukemia
    - Intussusception
  - Exclude children who are in hospice care for any part of the measurement period.
- Denominator Exceptions
  - Not applicable

Specification Guidance

- The measure allows a grace period by measuring numerator criteria with these recommendations between birth and age 2.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.

- Include children who turned 2 years of age during the measurement period, regardless of when they were seen for care during the year. Specifically, include them in the assessment whether the first visit in the year occurred before or after they turned 2.
- Include children in the denominator if they came to the health center for well-child[21] services or for any other medical visits, including treatment of an injury or illness.
- Include children in the denominator for whom no vaccination information is available and/or who were first seen at a point when there was not enough time to fully immunize them prior to their second birthday.
- Include children who had a contraindication for a specific vaccine in the denominator. Count them as being "CQM compliant" for that specific vaccine, if the guidance (Specification Guidance) permits it, and then review for the administration of the rest of the vaccines.
- To meet the numerator criteria, a child's health record must be documented as being CQM compliant for each vaccine.
- Registries can be used to fill any voids in the immunization record if the search is routinely done prior to or immediately after a visit and before the end of the measurement period, as long as the health IT/EHR is updated with the immunization details and coded correctly. For example, you may use an immunization registry maintained by the state or other public entity that shows comparable information.
- DO NOT include patients here or anywhere on the UDS who only received a vaccination and never received other services.
- DO NOT count as meeting the numerator criteria charts that only state that the "patient is up to date" with all immunizations and that DO NOT list the dates of all immunizations and the names of immunization agents.
- DO NOT count toward the numerator criteria verbal assurance from a parent or other individual that a vaccine has been given.
- Good-faith efforts to get a child immunized that fail DO NOT meet the numerator criteria. These include the following:
  - Parental failure to bring in the patient
  - Parents who refuse due to personal beliefs about vaccines or for religious reasons
  - Patients lost to follow-up

Cervical Cancer Screening (Line 11), CMS124v12

Measure Description

Percentage of women 21*–64 years of age who were screened for cervical cancer using **either** of the following criteria:

- Women age 21*–64 who had cervical cytology performed within the last 3 years
- Women age 30–64 who had human papillomavirus (HPV) testing performed within the last 5 years

*Use 24 as of December 31 as the initial age to include in assessment. See Specification Guidance for further detail.

[21] Health centers should add to their denominator those patients whose only visits were well-child visits (99381, 99382, 99391, 99392) if their automated system does not include them. In addition, if your state uses different codes for EPSDT visits, those codes should be added.

Calculate as follows:

Denominator: Columns A and B

- Women 24 through 64 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include women with birthdate on or after January 1, 1960, and birthdate on or before December 31, 2000.

Numerator: Column C

- Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:
    - Cervical cytology performed during the measurement period or the 2 years prior to the measurement period for women 24–64 years of age by the end of the measurement period.
    - Cervical HPV testing performed during the measurement period or the 4 years prior to the measurement period for women who are 30 years or older at the time of the test.

Exclusions/Exceptions

- Denominator Exclusions
    - Women who had a hysterectomy with no residual cervix or a congenital absence of cervix
    - Patients who were in hospice care for any part of the measurement period
    - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- To ensure the measure is looking for a cervical cytology test only after a woman turns 21 years of age, the youngest age in the initial population is 23.
- The measure may include screenings performed outside the age range of patients referenced in the initial population.
- Screenings that occur prior to the measurement period are valid to meet measure criteria.
- Evidence of high-risk human papillomavirus (hrHPV) testing within the last 5 years also captures patients who had cotesting, therefore, additional methods to identify cotesting are not necessary.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Include documentation in the patient health record of a cervical cytology and HPV tests performed outside of the health center with the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the test or a copy of the lab test.
- DO NOT count as CQM compliant charts that note the refusal of the patient to have the test.

Breast Cancer Screening (Line 11a), CMS125v12

Measure Description

Percentage of women 50*–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

*Use 52 on or after December 31 as the initial age to include in assessment. See Specification Guidance for further detail.

Calculate as follows:

Denominator: Columns A and B

- Women 52 through 74 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include women with birthdate on or after January 1, 1950, and birthdate on or before December 31, 1972.

Numerator: Column C

- Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period

Exclusions/Exceptions

- Denominator Exclusions
    - Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy on or before the end of the measurement period
    - Patients who were in hospice care for any part of the measurement period
    - Patients aged 66 and older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
    - Patients aged 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness (with one inpatient visit ***or*** two outpatient visits) or taking dementia medications during the measurement period or the year prior
    - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- The measure evaluates primary screening. DO NOT count biopsies, breast ultrasounds, or magnetic resonance imaging (MRI), because they are not appropriate methods for primary breast cancer screening.
- The measure only evaluates whether tests were performed after a woman turned 50 years of age. The youngest age in the initial population is 52.
- The measure may include screenings performed outside the age range of patients referenced in the initial population. Screenings that occur prior to the measurement period are valid to meet measure criteria.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- If a mammogram was performed outside of the health center, include documentation in the patient health record at the health center with the date the test was performed, who performed it, and the result of the finding provided by the agency that conducted the diagnostic study or a copy of the results.
- Include patients according to sex.
- DO NOT count as compliant for the CQM those charts that note the refusal of the patient to receive the screening or test.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Line 12), CMS155v12

Measure Description

Percentage of patients 3–17 years of age who had an outpatient visit with a **primary care physician (PCP) or obstetrician/gynecologist (OB/GYN)** and who had evidence of height, weight, and body mass index (BMI) percentile documentation **and** who had documentation of counseling for nutrition **and** who had documentation of counseling for physical activity during the measurement period

Calculate as follows:

Denominator: Columns A and B

- Patients 3 through 17 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include children and adolescents with birthdate on or after January 1, 2007, and birthdate on or before December 31, 2021.

Numerator: Column C

- Children and adolescents who have had:
    - their height, weight, and BMI percentile recorded during the measurement period ***and***
    - counseling for nutrition during the measurement period ***and***
    - counseling for physical activity during the measurement period.

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who have a diagnosis of pregnancy during the measurement period
    - Patients who were in hospice care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Because BMI norms for youth vary with age and sex, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Include qualifying encounters performed by any provider, as included in the specification criteria. Note that this is different from the eCQM description, which states that the visit must be performed by a PCP or an OB/GYN. For example, include patients who had a medical visit with an NP.
- The UDS numerator differs from the eCQM in that the eCQM requires the numerator elements to be reported separately against two age strata (age 3–11, age 12–17). For UDS purposes, the patients must have had all three numerator components completed in order to meet the numerator criteria using one age strata (age 3–17).
- DO NOT count as meeting the numerator criteria charts that show only that a well-child visit was scheduled, provided, or billed. The electronic or paper well-child visit template/form must document each of the elements noted above.
- Patient-reported height and weight are allowed to be used in this measure, provided the information is recorded in the EHR and is sufficiently accurate for use in clinical care. Determining the acceptability, reliability, and validity of patient-reported information is left to the discretion of the clinician.

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Line 13), CMS69v12

Measure Description

Percentage of patients aged 18 years and older with a BMI documented during the most recent visit or during the measurement period **and** who had a follow-up plan documented if BMI was outside of normal parameters

Note: Normal parameters: For age 18 years and older, BMI greater than or equal to 18.5 kg/m^2 and less than 25 kg/m^2

Calculate as follows:

Denominator: Columns A and B

- Patients 18 years of age or older on the date of the visit with at least one qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before January 1, 2006, who were 18 years of age or older on the date of their last visit.

Note: Patients who **only** had virtual visits during the year are NOT to be included in the denominator, according to the measure criteria.

Numerator: Column C

- Patients with a documented BMI during the most recent visit or during the measurement period, **and** BMI is within normal parameters, **and**

- Patients with a documented BMI during the most recent visit or during the measurement period, **and** when the BMI is outside of normal parameters, a follow-up plan is documented at the visit where the BMI was outside of normal parameters or during the measurement period

Note: Include in the numerator patients within normal parameters who had their BMI documented **and** those with a follow-up plan documented in the measurement period if BMI is outside normal parameters.

Exclusions/Exceptions

- Denominator Exclusions
  - Women who are pregnant at any time during the measurement period
  - Patients receiving palliative or hospice care at any time during the measurement period
- Denominator Exceptions
  - Patients who refuse measurement of height and/or weight
  - Patients with a documented medical reason for not documenting BMI or for not documenting a follow-up plan for a BMI outside normal parameters (see Specification Guidance)

Specification Guidance

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- An eligible professional or their personnel is required to measure both height and weight. Both height and weight must be measured during the measurement period.
- BMI may be documented in the patient health record at the health center or in outside patient health records obtained by the health center.
- If the documented BMI is outside of normal parameters, then a follow-up plan is to be documented during the visit **or** during the measurement period.
- If more than one BMI is reported during the measurement period, and any of the documented BMI assessments is outside of normal parameters, documentation of an appropriate follow-up plan is to be used to determine whether performance has been met.
- Document the follow-up plan based on the documented BMI outside of normal parameters.
- Documented medical reasons for denominator exceptions include, but are not limited to:
  - Elderly patients (65 years or older) for whom weight reduction or gain would complicate other underlying health conditions, such as the following examples:
    - Illness or physical disability
    - Mental illness, dementia, confusion
    - Nutritional deficiency, such as vitamin or mineral deficiency
    - Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- DO NOT use self-reported height and weight values.

UDS Reporting Considerations

- Documentation in the patient health record must show the actual BMI, or the template normally viewed by a provider must display BMI.
- A follow-up plan may include, but is not limited to documentation of education, referral (for example, a registered dietitian nutritionist [RDN], occupational therapist, physical therapist, PCP, exercise physiologist, mental health professional, or surgeon) for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling, and/or nutrition counseling.
- If the **only** visits during the year are telehealth and/or telephone visits, exclude the patient from the denominator.
- DO NOT count as meeting the numerator criteria charts or templates that display only height and weight. The fact that a health IT/EHR can calculate BMI does not replace the presence of the BMI itself.

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Line 14a), CMS138v12

Measure Description

Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period **and** who received tobacco cessation intervention during the measurement period or in the 6 months prior to the measurement period if identified as a tobacco user

Calculate as follows:

Denominator: Columns A and B

- Patients aged 12 years and older at the start of the measurement period seen for at least two qualifying encounters in the measurement period or at least one preventive care qualifying encounter during the measurement period, as specified in the measure criteria
  - Include patients with birthdate on or before January 1, 2012.

Numerator: Column C

- Patients who were screened for tobacco use at least once during the measurement period and NOT identified as a tobacco user, **and**
- Patients who were screened for tobacco use at least once during the measurement period **and**, if identified as a tobacco user, received tobacco cessation intervention during the measurement period or during the 6 months prior to the measurement period

Note: Include in the numerator patients with a negative screening **and** those with a positive screening who had cessation intervention if a tobacco user.

Exclusions/Exceptions

- Denominator Exclusions
  - Patients who were in hospice care for any part of the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- If patients use any type of tobacco (i.e., smokes or uses smokeless tobacco), tobacco cessation intervention (counseling and/or pharmacotherapy) is expected. The measure uses the U.S. Food and Drug Administration definition of tobacco, which includes e-cigarettes, hookah pens, and other electronic nicotine delivery systems. Therefore, the measure does consider the use of e-cigarettes and other electronic nicotine delivery systems to be tobacco use.
- A patient needs one preventive visit to be considered for the dominator. Preventive visits are defined by the value sets listed under *Preventive Visit During Measurement Period* in the measure specifications. If a patient has not had a preventive visit, they need two other qualifying visits to be considered for the denominator. Other qualifying visits are defined by the value sets listed under *Qualifying Visit During Measurement Period* in the measure specifications.
- To promote a team-based approach to patient care, the tobacco cessation intervention can be performed by another health care provider; therefore, the tobacco use screening and tobacco cessation intervention DO NOT need to be performed by the same provider.
- If a patient has multiple tobacco use screenings during the measurement period, use the most recent screening that has a documented status of tobacco user or non-user.
- If tobacco use status of a patient is unknown, the patient does NOT meet the screening component required to be counted in the numerator and has not met the numerator criteria. "Unknown" includes patients who were not screened and patients with indefinite answers.

UDS Reporting Considerations

- Report in the numerator records that demonstrate that the patient had been asked about their use of all forms of tobacco during the measurement period.
- If the cessation intervention is pharmacotherapy, then the prescription must be active (one that has not expired) or ordered during the measurement period.
- Include patients who receive tobacco cessation intervention by any provider, including those who:
  - received tobacco use cessation counseling services, **or**
  - received an order for (a prescription or a recommendation to purchase an over-the-counter product) a tobacco use cessation medication, **or**
  - are on (using) a tobacco use cessation agent.
- The UDS denominator differs from the eCQM in that the eCQM requires the patient population and numerator to be reported separately; for UDS purposes, the patients must be evaluated as one group.
- DO NOT count as meeting the numerator criteria providing written self-help materials only.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Line 17a), CMS347v7

Measure Description

Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or have ever had an ASCVD procedure, **or**
- Patients 20 through 75 years of age who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, **or**
- Patients 40 through 75 years of age with a diagnosis of diabetes, **or**
- Patients 40 through 75 years of age with a 10-year ASCVD risk score greater than or equal to 20 percent

Calculate as follows:

Denominator: Columns A and B

To prevent patients from being counted more than once in the denominator, identify patients meeting the criteria listed in the first bullet below. If a patient is identified, they meet the risk requirement and are included in the denominator. If the patient is **not** identified from the first criteria, move to the next. Continue through the four categories of risk criteria to identify individual patients at high risk of cardiovascular events.

- All patients who were previously diagnosed with or currently have a diagnosis of ASCVD, including an ASCVD procedure +
- Patients who were 20 through 75 years of age at the start of the measurement period who:
  - ever had a laboratory result of LDL-C greater than or equal to 190 mg/dL **or**
  - were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia +
- Patients 40 through 75 years of age at the start of the measurement period with type 1 or type 2 diabetes +
- Patients aged 40 through 75 at the start of the measurement period with a 10-year ASCVD risk score greater than or equal to 20 percent during the measurement period
- With a qualifying encounter during the measurement period, as specified in the measure criteria
- Include patients:
  - of any age for the ASCVD determination;
  - with birthdate on or before January 1, 2004 for LDL-C or familial hypercholesterolemia determination;
  - with birthdate on or after January 2, 1948, and birthdate on or before January 1, 1984 for diabetes determination; and
  - with birthdate on or after January 2, 1948, and birthdate on or before January 1, 1984 for high 10-year ASCVD risk score.

Numerator: Column C

- Patients who are actively using or who received an order (prescription) for statin therapy at any time during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Women who are breastfeeding at any time during the measurement period
  - Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period
- Denominator Exceptions
  - Patients with statin-associated muscle symptoms or an allergy to statin medication
  - Patients who are receiving palliative or hospice care
  - Patients with active liver disease or hepatic disease or insufficiency
  - Patients with end-stage renal disease (ESRD)
  - Patients with documentation of a medical reason for not being prescribed statin therapy

Specification Guidance

- Current statin therapy (including statin medication samples provided to patients) must be documented in the patient's current medication list or ordered during the measurement period.
- Ensure patients are not counted in the denominator more than once. Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), they are included and further risk checks are not needed.
- Intensity of statin therapy or lifestyle modification coaching is **NOT** being assessed for this measure; only prescription or use of any statin therapy is being assessed.
- DO NOT count *other* cholesterol-lowering medications as meeting the numerator criteria; only statin therapy meets the numerator criteria.
- Patient adherence to statin therapy is not calculated in this measure.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- If the **only** visits during the year are telephone visits, exclude the patient from the denominator.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (Line 18), CMS164v7

Measure Description

Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period **or** who had an **active** diagnosis of IVD during the measurement period, and who had documented use of aspirin or another antiplatelet during the measurement period

Calculate as follows:

Denominator: Columns A and B

- Patients 18 years of age and older with a qualifying encounter during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement period **or** who had a diagnosis of IVD overlapping the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before January 1, 2006.

Numerator: Column C

- Patients who had an active medication of aspirin or another antiplatelet during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who had documentation of use of anticoagulant medications overlapping the measurement period
    - Patients who were in hospice care during the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- The electronic specifications for this measure have not been updated. Follow the CMS164v7 specifications for UDS reporting.

Colorectal Cancer Screening (Line 19), CMS130v12

Measure Description

Percentage of adults 45*–75 years of age who had appropriate screening for colorectal cancer

*Use 46 on or after December 31 as the initial age to include in assessment.

Calculate as follows:

Denominator: Columns A and B

- Patients 46 through 75 years of age by the end of the measurement period with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or after January 1, 1949, and birthdate on or before December 31, 1978.

Numerator: Column C

- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any **one** of the following criteria:
  - Fecal occult blood test (FOBT) during the measurement period
  - Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT)- during the measurement period or the 2 years prior to the measurement period
  - Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
  - Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period
  - Colonoscopy during the measurement period or the 9 years prior to the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Patients with a diagnosis or past history of colorectal cancer or total colectomy
  - Patients who were receiving palliative care or hospice care for any part of the measurement period
  - Patients aged 66 or older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
  - Patients aged 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits during the measurement period or the year prior; or taking dementia medications during the measurement period or the year prior
- Denominator Exceptions
  - Not applicable

Specification Guidance

- DO NOT count digital rectal exam (DRE) or FOBT tests performed in an office setting or performed on a sample collected via DRE.
- The measure may include screenings performed outside the age range of patients referenced in the initial populations. Screenings that occur prior to the measurement period are valid to meet the measure criteria.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- There are two FOBT test options: the guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT).
- Lab tests (FOBT and sDNA with FIT) performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.
- FOBTs can be used to document meeting the numerator criteria. This test, if performed, is required each measurement period. For example, a patient who had an FOBT in November 2023 would still need one in 2024.

- Collect stool specimens for FOBT and sDNA with FIT, as recommended by the manufacturer.
- FOBT and sDNA with FIT test kits can be mailed to patients, but receipt, processing, and documentation of the test sample is required.
- DO NOT use self-reported test results.

HIV Linkage to Care (Line 20), No eCQM

Measure Description

Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 30 days of diagnosis[22]

Calculate as follows:

Denominator: Columns A and B

- Patients first diagnosed with HIV by the health center between December 1 of the prior year through November 30 of the current measurement period and who had at least one qualifying encounter during the measurement period or prior year, as specified in the measure criteria
    - Include patients who were diagnosed with HIV for the first time ever[23] by the health center between December 1, 2023, and November 30, 2024,[24] and had at least one visit during 2024 or 2023.

Numerator: Column C

- Newly diagnosed HIV patients that received treatment within 30 days of diagnosis. Include patients who were newly diagnosed by your health center providers **and**:
    - had a visit with your health center provider who initiates treatment for HIV, **or**
    - had a visit with a referral resource who initiates treatment for HIV.

Exclusions/Exceptions

- Denominator Exclusions
    - Not applicable
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.

[22] Note that this measure does not conform to the calendar year reporting requirement.
[23] "Patients first diagnosed with HIV" is defined as patients without a previous HIV diagnosis who received a reactive initial HIV test confirmed by a positive supplemental antibody immunoassay HIV test.
[24] Because the measure allows up to 30 days to complete the follow-up, look back 30 days to find the entire denominator of patients who should have had a follow-up during the measurement period.

- **Treatment must be initiated** within 30 days of the HIV diagnosis (NOT just a referral made, education provided, or retest at a referral site).
- Include patients in the numerator only if they received treatment for HIV care within 30 days of the diagnosis.
- If the treatment is by referral to another provider or organization (such as a Ryan White provider), the treatment at the referral source must begin during the 30-day period. Documentation that the visit was completed (from the provider to whom the patient was referred) is required.
- Identification of patients for this measure crosses years and may include prior-year patients.
- Reactive initial HIV tests and patients who self-identify as being HIV positive without documentation must be followed by a supplemental test to confirm diagnosis.
- DO NOT include patients who:
  - Were diagnosed elsewhere, even if they can provide documentation of the positive test result
  - Had a positive reactive initial screening test but not a positive supplemental test
  - Were positive on an initial screening test provided by you but were then sent to another provider for definitive testing and treatment

Note: There are no ICD-10-CM or CPT codes to identify newly diagnosed HIV patients. It is strongly encouraged that you modify your health IT/EHR to record this information or keep track of the patients who are identified in a separate system.

HIV Screening (Line 20a), CMS349v6

Measure Description

Percentage of patients aged 15–65 at the start of the measurement period who were between 15–65 years old when tested for HIV

This is calculated as follows:

Denominator: Columns A and B

- Patients aged 15 through 65 years of age at the start of the measurement period who had at least one outpatient qualifying encounter during the measurement period, as specified in the measure criteria
  - Include patients with birthdate on or after January 2, 1958, and birthdate on or before January 1, 2009.

Numerator: Column C

- Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday

Exclusions/Exceptions

- Denominator Exclusions
  - Patients diagnosed with HIV prior to the start of the measurement period
- Denominator Exceptions
  - Patients who died on or before the end of the measurement period

Specification Guidance

- This measure evaluates the proportion of patients aged 15–65 at the start of the measurement period who have documentation of having received an HIV test at least once on or after their 15th birthday and before their 66th birthday.
- To satisfy the measure, the health center must have documentation of the administration of the laboratory test present in the patient's health record.
- HIV tests performed elsewhere must be confirmed by documentation in the chart: either a copy of the test results or correspondence between the clinic personnel and the performing lab/provider showing the results.
- Patient attestation or self-report to meet the measure requirements is NOT permitted.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- If the **only** visits during the year are telephone visits, exclude the patient from the denominator.

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Line 21), CMS2v13

Measure Description

Percentage of patients aged 12 years and older screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool **and**, if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying visit

This is calculated as follows:

Denominator: Columns A and B

- Patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before January 1, 2012.

Numerator: Column C

- Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and screened negative for depression
- Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool, and if screened positive for depression, a follow-up plan is documented on the date of or up to two days after the date of the qualifying visit

Note: Include in the numerator patients with a negative screening and those with a positive screening who had a follow-up plan documented.

Exclusions/Exceptions

- Denominator Exclusions
    - Patients who have been diagnosed with bipolar disorder at any time prior to the qualifying encounter, regardless of whether the diagnosis is active or not

- Denominator Exceptions
  - Patients who refuse to participate in or complete the depression screening
  - Medical reason(s), including:
    - Patients who are in urgent or emergent situations[25] where time is of the essence and to delay treatment would jeopardize the patient's health status
    - Patients with documentation of medical reason for not screening the patient for depression (e.g., cognitive, functional, or motivational limitations) that may impact the accuracy of results

Specification Guidance

- Patients who have ever been diagnosed with bipolar disorder prior to the qualifying encounter will be excluded from the measure.
- The depression screening must be completed on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized depression screening tool and must be reviewed and addressed in the office of the provider on the date of the visit.
- Numerator should be evaluated and reported based on the screening outcome.
- If the screening result is positive, a follow-up plan must be documented on the date of the visit or up to two days after the visit. A follow-up plan could be additional evaluation, referral, treatment, pharmacological intervention, or other interventions.
- Standardized depression screening tools[26] are normalized and validated for the age-appropriate patient population in which they are used, must be documented in the patient health record, and must be used to meet the numerator criteria.
  - Examples of depression screening tools for adolescents, adults, and perinatal patients are included in the FAQ for Table 6B.
  - Document the screening tool used in the patient health record. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression.
- Use the most recent screening results.
- The follow-up plan must be related to a positive depression screening.
- Follow-up for a positive depression screening must include one or more of the following:
  - Additional interventions designed to treat depression, such as behavioral health evaluation, psychotherapy, or additional treatment.
  - Referral to a provider for further evaluation for depression.
  - Pharmacological interventions, when appropriate.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.

[25] Do not exclude patients seen for routine care in urgent care centers or emergency rooms you operate.
[26] Refer to the publisher and the health center clinical team to interpret the results of screening tools.

- Although a Patient Health Questionnaire (PHQ-9)[27] may follow a PHQ-2 as a **new screening**, if the result is positive, then a CQM-compliant follow-up plan on the date of the visit is still required.
- Screening may occur outside of a countable visit.
- Count eligible patients once in the denominator, regardless of how many times they were screened.
- Documentation of a follow-up plan "on the date of the visit" can refer to any countable visit, NOT only a medical visit.
- A suicide risk assessment DOES NOT qualify for the numerator as a follow-up plan.
- DO NOT count patients who are re-screened as meeting the numerator criteria as a follow-up plan to a positive screen.
- DO NOT count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the numerator criteria for a **follow-up** plan to a positive depression screening.

Depression Remission at Twelve Months (Line 21a), CMS159v12

Measure Description

Percentage of patients aged 12 years and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event

This is calculated as follows:

Denominator: Columns A and B

- Patients aged 12 years and older at the start of the measurement period with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event between November 1, 2022, through October 31, 2023, and at least one qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or before November 1, 2010, who were 12 years of age or older on the date of the index event.

Note: Patients may be screened using PHQ-9 and PHQ-9M on the same date or up to 7 days prior to the visit (index event).

Numerator: Column C

- Patients who achieved remission at 12 months as demonstrated by the most recent 12-month (+/- 60 days) PHQ-9 or PHQ-9M score of less than 5

Exclusions/Exceptions

- Denominator Exclusions
    - Patients with a diagnosis of bipolar disorder, personality disorder emotionally labile, schizophrenia, psychotic disorder, or pervasive developmental disorder

[27] A PHQ is a screening instrument used by providers to monitor the severity of depression and response to treatment.

  - Patients:
    - Who died
    - Who received hospice or palliative care services
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Although PHQ-9 is not the only screening tool approved for the **Screening for Depression and Follow-Up Plan** measure, performance for the **Depression Remission at Twelve Months** must be evaluated using a PHQ-9 or PHQ-9M screening tool.
- It is possible that the PHQ-9M has been mislabeled as PHQ modified for adolescents (PHQ-A). The PHQ-A is an 80+ item questionnaire (not a 9-question tool). Use a PHQ-9M version that is approved by the developers of the PHQ-9 for adolescents.
- The index event is the date the patient had an initial PHQ-9 or PHQ-9M (modified for teens) score greater than 9 and a diagnosis of major depression or dysthymia during the time period between November 1, 2022, through October 31, 2023.
- Count eligible patients once in the denominator, regardless of how many times they were screened.

Dental Sealants for Children between 6–9 Years (Line 22), CMS277v0[28]

Measure Description

Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period

Note: Although the draft eCQM reflects 5 through 9 years of age, use ages 6 through 9 as the measure steward intended. This includes patients who were 9 years of age at the beginning of the measurement period.

Calculate as follows:

Denominator: Columns A and B

- Children 6 through 9 years of age at the start of the measurement period with an oral assessment or comprehensive or periodic oral evaluation qualifying encounter who are at moderate to high risk for caries in the measurement period, as specified in the measure criteria
  - Include children with birthdate on or after January 2, 2014, and birthdate on or before January 1, 2018.

[28] Access measure value set details on the Clinical Care page of the UDS Training and Technical Assistance webpage.

Numerator: Column C

- Children who received a sealant on a permanent first molar tooth during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Not applicable
- Denominator Exceptions
  - Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)

Specification Guidance

- The intent is to measure whether a child received a sealant on at least one of the four permanent first molars.
- "Elevated risk" must be a finding at the patient level, NOT a population-based factor such as low socioeconomic status.
- Look for tooth-level data for sealant placement. Capture sealant application within buccal pits on a first permanent molar in the numerator.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Include dental sealants placed by the health center or by another dental provider who saw health center dental patients through a referral, regardless of whether it was paid for by the health center.
- Use ADA codes to document caries risk level determined through an assessment.
- The electronic specifications for this measure have not been updated. Follow the CMS277v0[29] specifications for UDS reporting.

FAQ FOR TABLE 6B

1. On which line do we count patients who began prenatal care during the first trimester?

Report the patient on Line 7, and in Column A or B depending on if they began their care with the health center or with a non–health center provider. For example:

- If the patient began prenatal care during the first trimester at a health center's service delivery location or with a provider to which the health center referred the patient, report the patient on Line 7 in Column A.
- If the patient received prenatal care from another provider during the first trimester before coming to the health center's service delivery location, report the patient on Line 7 in Column B, regardless of when the patient begins care with the health center or through direct referral from the health center to another provider.

[29] Contact the UDS Support Center to access measure details.

2. **What timeframe is used to determine each of the trimesters of entry into prenatal care?**

   The trimesters of entry into prenatal care are as follows:

   - First trimester: 0 weeks–13 and 6/7 weeks (months 1–3)
   - Second trimester: 14 and 0/7 weeks–27 and 6/7 weeks (months 4–6)
   - Third trimester: 28 and 0/7 weeks–40 and 6/7 weeks (months 7–9)

3. **If a prenatal care patient from the prior year delivered during 2024, would we include the patient as a prenatal care patient in the 2024 UDS Report?**

   Yes. The prenatal care patient would be included in the 2024 UDS Report as a prenatal care patient on Table 6B, and delivery outcomes will be reported on Table 7, even if they had no other visit in the calendar year.

4. **A child came in only once during the year for an injury and never returned for well-child care. Do we have to consider the child's chart to not have met the numerator criteria since we only treated for the injury?**

   Yes. After a patient enters a health center's system of care, the center is expected to provide all needed preventive health care and/or document that the patient has received it. If the visit they had is coded with an eligible visit for inclusion in the denominator of the CQM, report the patient in the denominator but NOT the numerator, since the record did not meet the numerator criteria.

5. **Is the cervical cancer screening review for women starting at age 21 or at age 23?**

   For this measure, look only at women who were age 23 through age 64 at some point in the measurement period. Because the measure asks about Pap tests **administered** in 2024, 2023, or in 2022, it is possible that a 23-year-old woman assessed under this measure would have been 21 in 2022. If the patient received a Pap test in that year, the patient would be considered to have met the numerator criteria. Although you look only at women who are 24 through 64 by the end of the measurement period, their qualifying test may have been done when they were 21 through 64.

6. **What if a patient we treat for hypertension and diabetes goes to an OB/GYN in the community for reproductive health care? Do we still have to consider the patient in the denominator for the cervical cancer screening measure? What if we DO NOT offer Pap tests?**

   After the patient has been seen in your clinic, you are responsible for ensuring that they have the appropriate cervical cancer screening. This can be done by providing the Pap test or documenting the results of a test that someone else performed. Health centers are encouraged to coordinate care and document Pap test results by contacting providers. The health center may obtain a copy of the patient's test result to include in their patient health record to inform their future care. Consider the patient as part of the denominator for the cervical cancer screening measure if they had a **qualifying encounter**, as specified in the measure criteria, in the measurement period. If there is no evidence of a timely cervical cancer screening included in their patient health record, consider this as NOT having met the numerator criteria.

7. **If we inform parents of the importance of immunizations but they refuse to have their child immunized, may we count the patient health record as having met the numerator criteria if the refusal is documented?**

   No. A child is fully immunized only if there is documentation that the child received the vaccine or there is contraindication for the vaccine, evidence of the antigen, or history of illness. Refusal does NOT meet the exclusion criteria.

8. **Are parents required to bring to the health center documentation of childhood immunizations received outside the health center?**

   When possible, health centers are encouraged to access childhood immunizations provided outside the health center through health information exchange or through read-only EHR access to immunization information systems, or through other health information exchange-facilitated means. If health information exchange access to this information is not available, parents are encouraged to provide documentation of immunizations that their children received elsewhere. Documentation of childhood immunizations may also be obtained by contacting providers of immunizations directly to obtain documentation by fax or email, by requesting health center patients mail a copy of their immunization history, through receipt of payment for the vaccine from the pharmacy, by finding the child in a state or county immunization registry, or through other appropriate means.

9. **Some of the immunization details are different from those used by the Centers for Disease Control and Prevention (CDC) in the Clinic Assessment Software Application (CASA) or Comprehensive-CASA (coCASA) reviews of our clinic. May we use these CDC standards to report on the UDS?**

   No. HRSA is now using the CMS eCQM standards to evaluate provision of vaccines to children. Using a different set of standards will distort the data. A health center **may** use a different set of standards for its own internal QI/quality assurance program, but these may not be substituted for the UDS reporting requirements.

10. **Does "counseling for nutrition and . . . physical activity" include specific content that must be provided? Does it need to be provided if the child is within the normal range?**

    No, the counseling has no specific required content, although it does have specific CPT coding requirements. It is tailored by the provider given the patient's BMI percentile and other clinical and social data.

    Yes, the counseling must be provided to all children and adolescents. Counseling is aimed at promoting routine physical activity and healthy eating for **all** children and adolescents. For younger children, counseling will be provided to the parent or caregiver.

11. **For adult patients, our protocol calls for weight to be measured at every visit but height to be measured "at least once every 2 years." Is this acceptable?**

    No. BMI is calculated using height and weight reported during the measurement period. Height and weight may be obtained from separate visits, as long as both are measured during the most recent visit or during the measurement period.

12. **The tobacco screening measure says that there must be intervention for tobacco users. What specific interventions must be used?**

    A broad range of counseling and pharmacotherapy is available for tobacco use. Which intervention to use is at the discretion of each provider.

13. **Do quit lines meet the numerator criteria for tobacco cessation?**

    Yes. Tobacco cessation services provided by quit lines do meet the numerator criteria for the tobacco screening and cessation intervention measure if the intervention is documented in the patient's health record.

14. **How should we collect data for measures that require a look-back period?**

    Many of the UDS CQMs (e.g., cervical cancer screening, colorectal cancer screening, childhood immunizations, others) require a look-back period (reference to historical data prior to the measurement period). It is important that this information is noted in patient health records. It is recommended that you obtain records for new patients from their former providers to document their prior treatment, including data for look-back periods. Patient health records obtained from other providers may be recorded in the health

center's health IT/EHR consistent with internal patient health record policies, at which point they could be used in the performance review. Additionally, if you change EHRs, ensure that the prior data are transferred to the new system.

15. Can we use National Quality Forum (NQF) or Healthcare Effectiveness Data and Information Set (HEDIS) directly to report on the CQMs?

No. For UDS reporting, you must report on the CQMs defined by UDS and outlined in this manual, most of which align with CMS's Promoting Interoperability eCQMs.

16. Which patients are we required to report in the denominator for the dental sealants measure?

Health centers providing dental services directly on-site or through paid referral under contract must report on all dental patients age 6 through 9 at the start of the measurement period who are at elevated risk for caries in the denominator. Caries risk assessment must be based on patient-level factors and documented with appropriate ADA codes. This may not be based on population-based factors, such as low socioeconomic status.

17. Do DNA colorectal cancer screening tests meet the numerator criteria for the colorectal cancer screening measure?

Yes. Stool DNA (sDNA) with FIT colorectal cancer screening tests (such as Cologuard) meet the numerator criteria for the colorectal cancer screening measure when performed during the measurement period or in the 2 years prior.

18. If a patient who is newly diagnosed with HIV dies before they receive treatment, do we count them in the HIV linkage to care measure?

Yes. Include the patient in the denominator, assuming they met the diagnosis criteria. If they died before receiving the first visit for initiation of treatment, DO NOT count them in the numerator.

19. Can brand-name prescriptions meet the numerator criteria for measures that include a pharmaceutical component?

Yes. Since only scientific or generic names are stored in the RxNORM value sets, the health center and vendor need to map the generic and brand names when a new equivalent or brand name is discovered missing from RxNORM.

20. What does "diagnosis that overlaps the measurement period" mean, as stated for some of the measures?

The overlap statement means that if patients had the diagnosis at any point during the measurement period, they are to be included in the denominator and assessed for meeting the numerator criteria.

21. If we are able to see that the patient has received a needed service (such as a mammogram or colonoscopy), such as through our health information exchange or read-only EHR access, can we count that toward CQM compliance?

Yes. If a needed service is viewable and accessible in the patient health record directly, or through health information exchange or read-only EHR access, it may count toward CQM compliance as long as it meets the specified numerator criteria.

22. What do we need to do in the reporting of specific eCQMs that we have identified to have a denominator exclusion?

Patients who have been identified to have met a denominator exclusion during the numerator criteria check need to be removed from the numerator and denominator (and should no longer be considered for the measure).

23. We would like to recommend changes to specific eCQM requirements being collected in the UDS. Can HRSA make the changes based on our feedback?

Although HRSA is interested in learning about eCQM changes you would recommend, you should contact the measure steward through the ONC Issue Tracking System to submit recommendations to existing eCQM logic. Appendix H contains the list of measure stewards.

24. What standardized depression screenings comply with the Screening for Depression and Follow-Up Plan measure?

Use a standardized depression screening tool, which is a normalized and validated tool developed for the patient population in which it is to be utilized. Examples of depression screening tools include, **but are not limited to those listed in the following chart**:

Adolescent Screening Tools (12–17 years)	Adult Screening Tools (18 years and older)	Perinatal Screening Tools
• Patient Health Questionnaire for Adolescents (PHQ-A) • Beck Depression Inventory-Primary Care Version (BDI-PC) • Mood Feeling Questionnaire (MFQ) • Center for Epidemiologic Studies Depression Scale (CES-D) • Patient Health Questionnaire (PHQ-9) • Pediatric Symptom Checklist (PSC-17) • Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2	• PHQ-9 • Beck Depression Inventory (BDI or BDI-II) • CES-D • Depression Scale (DEPS) • Duke Anxiety-Depression Scale (DADS) • Geriatric Depression Scale (GDS) • Cornell Scale for Depression in Dementia (CSDD) • PRIME MD-PHQ-2 • Hamilton Rating Scale for Depression (HAM-D) • Quick Inventory of Depressive Symptomatology Self-Report (QID-SR) • Computerized Adaptive Testing Depression Inventory (CAT-DI) • Computerized Adaptive Diagnostic Screener (CAD-MDD)	• Edinburgh Postnatal Depression Scale • Postpartum Depression Screening Scale • PHQ-9 • BDI • BDI-II • CES-D • Zung Self-Rating Depression Scale

TABLE 6B: QUALITY OF CARE MEASURES

Calendar Year: January 1, 2024, through December 31, 2024

0	Prenatal Care Provided by Referral Only (Check if Yes)	[blank for demonstration]

Section A—Age Categories for Prenatal Care Patients: Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)
1	Less than 15 years	
2	Ages 15–19	
3	Ages 20–24	
4	Ages 25–44	
5	Ages 45 and over	
6	**Total Patients (Sum of Lines 1–5)**	

Section B—Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Patients Having First Visit with Health Center (a)	Patients Having First Visit with Another Provider (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Section C—Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number of Records Reviewed (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday			

Section D—Cervical and Breast Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 24 through 64 (a)	Number of Records Reviewed (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 24–64 years of age who were screened for cervical cancer			
Line	**Breast Cancer Screening**	**Total Female Patients Aged 52 through 74 (a)**	**Number of Records Reviewed (b)**	**Number of Patients with Mammogram (c)**
11a	MEASURE: Percentage of women 52–74 years of age who had a mammogram to screen for breast cancer			

Section E—Weight Assessment and Counseling for Nutrition and Physical Activity of Children/Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Total Patients Aged 3 through 17 (a)	Number of Records Reviewed (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3–17 years of age with a BMI percentile **and** counseling on nutrition **and** physical activity documented			

Section F—Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number of Records Reviewed (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters			

Section G—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 12 and Older (a)	Number of Records Reviewed (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 12 years of age and older who (1) were screened for tobacco use one or more times during the measurement period, **and** (2) if identified to be a tobacco user received cessation counseling intervention			

Section H—Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients at High Risk of Cardiovascular Events (a)	Number of Records Reviewed (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy			

Section I—Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number of Records Reviewed (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet			

Section J—Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 46 through 75 (a)	Number of Records Reviewed (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 46 through 75 years of age who had appropriate screening for colorectal cancer			

Section K—HIV Measures

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number of Records Reviewed (b)	Number of Patients Seen Within 30 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first-ever HIV diagnosis was made by health center personnel between December 1 of the prior year and November 30 of the measurement period and who were seen for follow-up treatment within 30 days of that first-ever diagnosis			
Line	**HIV Screening**	**Total Patients Aged 15 through 65 (a)**	**Number of Records Reviewed (b)**	**Number of Patients Tested for HIV (c)**
20a	MEASURE: Percentage of patients 15 through 65 years of age who were tested for HIV when within age range			

Section L—Depression Measures

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number of Records Reviewed (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and,* if screening was positive, (2) had a follow-up plan documented			
Line	**Depression Remission at Twelve Months**	**Total Patients Aged 12 and Older with Major Depression or Dysthymia (a)**	**Number of Records Reviewed (b)**	**Number of Patients who Reached Remission (c)**
21a	MEASURE: Percentage of patients 12 years of age and older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event			

Section M—Dental Sealants for Children between 6–9 Years

Line	Dental Sealants for Children between 6–9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number of Records Reviewed (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar			

Table 6B Cross-Table Considerations:

- Patients with countable visits on Table 5 are generally eligible for inclusion in eCQMs reported on Table 6B.
- The relationship between the denominators on Table 6B should be verified as reasonable when compared to the total number of patients by age on Table 3A and the percentage of patients by service category on Table 5.
- The count of patients by diagnosis reported on Table 6A will NOT be the same count as on Table 6B, due to differences in criteria that must be met for inclusion on Table 6B.

Instructions for Table 7: Health Outcomes

The health outcome measures reported on Table 7 are "clinical process and outcome measures," which means they document measurable outcomes of clinical intervention as a surrogate for good long-term health outcomes. Increasing the proportion of health center patients who have a good intermediate health outcome generally leads to improved health status of the patient population in the future.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

Several notable changes have been made to Table 7, as outlined below:

- The specifications for the clinical quality measures reported have been revised to align with the CMS eCQMs. The clinical quality of care measures are aligned with the most current eCQMs for Eligible Professionals for the 2024 version number referenced in the UDS Manual for the measurement period. (Later version updates are available, but they should not be used for the 2024 reporting.)
- In addition to submitting this table as described below within the EHBs, health centers may submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.
- UDS+ data submission will be required for certain UDS tables. The minimum submission requirements for 2024 will be announced on the UDS Modernization Initiative and Health Center Program Community[30] websites.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

TABLE 7: HEALTH OUTCOMES MEASURES – INSTRUCTIONS

This table specifically includes the following CQMs:

Maternal Care and Children's Health	Disease Management
• Low Birth Weight	• Controlling High Blood Pressure • Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

RACE AND ETHNICITY REPORTING

- Race and Hispanic, Latino/a, or Spanish ethnicity are self-reported by patients and should be collected as part of a standard registration process.
- Care must be taken by health centers that have separate reporting systems for patient registration and clinical data to ensure race and ethnicity data across the systems are aligned.
- Because the initial patient population for each measure is defined in terms of race and ethnicity, comparisons between the numbers on Tables 3B and 7 will be made when evaluating your submission. See the crosswalk of comparable fields in Appendix B.

Note: The reporting of patients' race and ethnicity on the UDS uses HHS data standards, which are a disaggregation of OMB standards and may differ from the race and ethnicity levels required for other eCQM reporting programs.

[30] Login credentials are required. Users may request access through the Health Center Program Community.

Note: The "Subtotal Hispanic, Latino/a, or Spanish Origin" and "Subtotal Not Hispanic, Latino/a, or Spanish Origin" lines are grayed out on all three sections of Table 7. They are provided as a system-generated subtotal in the EHBs.

SECTION A: DELIVERIES AND BIRTH WEIGHT

HIV-POSITIVE PREGNANT WOMEN, TOP LINE (LINE 0)

- Report the total number of HIV-positive pregnant women served by the health center during the calendar year on Line 0, regardless of whether the health center provides prenatal care or HIV treatment for these patients.

DELIVERIES PERFORMED BY HEALTH CENTER PROVIDER (LINE 2)

- Report the total number of deliveries performed by health center providers.
- On this line ONLY, include deliveries, regardless of outcome, of any patient, regardless of whether or not she was part of the health center's prenatal care program during the calendar year. Include such circumstances as:
    - the delivery of another doctor's patients when the health center provider participates in a call group and is on call at the time of delivery,
    - emergency deliveries when the health center provider is on call for the emergency room, and
    - deliveries of non–health center patients performed by a health center provider as a requirement for privileging at a hospital.
- DO NOT include deliveries for which a clinic provider separately bills, receives, and retains payment for the delivery, such as in a moonlighting situation.

DELIVERIES AND BIRTH WEIGHT DATA BY RACE AND HISPANIC, LATINO/A, OR SPANISH ETHNICITY, COLUMNS 1A–1D

- Report ***all*** health center prenatal care patients who delivered during the calendar year who were either provided direct care at the health center or referred for care by the health center in Column 1a. Include any patient of the health center who was referred to another provider for some or all of her prenatal care. These patients must also be included in the prenatal care counts on Table 6B.
- Report ***all*** babies born to health center prenatal care patients who delivered during the calendar year in Columns 1b–1d.
- Report patients delivering (Column 1a) and babies (Columns 1b, 1c, and 1d) separately by their race and ethnicity. Obtain race and ethnicity of mothers from the information on their patient registration forms. Obtain race and ethnicity of babies from their registration forms, their birth certificates, or from their parent. Use race and ethnicity reporting criteria, including the subcategories, as provided on Table 3B.

Prenatal Care Patients and Referred Prenatal Care Patients Who Delivered During the Year (Column 1a)

- Report all health center prenatal care patients who delivered during the calendar year, including those who health center personnel cared for and delivered and those who had some or all of their care (including delivery) provided by a referral provider.
- This column collects data on "patients who delivered." Report one patient as having delivered, even if the delivery results in multiple births (e.g., twins or triplets), or is a stillbirth.

- Include all patients who had deliveries, regardless of the outcome.
- DO NOT include deliveries when you have no documentation that the delivery occurred (patients lost to follow-up).
- DO NOT include patients who, based on their due date, should have delivered but for whom you DO NOT have explicit documentation of the delivery.
- DO NOT include miscarriages as deliveries.

Note: The percentage of prenatal care patients who delivered can be calculated by dividing Table 7, Line i, Column 1a by Table 6B, Line 6, Column A. Use the cross-table guidance in Appendix B on the relationship between prenatal care on Table 6B and deliveries on Table 7 to assist with this reporting.

Birth Weight of Infants Born to Prenatal Care Patients Who Delivered During the Year (Columns 1b–1d)

Low Birth Weight (Columns 1b and 1c), no eCQM

Measure Description

Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)

Note: The reporting of this measure captures all birth weight categories.

Calculate as follows:

Denominator: Columns 1b + 1c + 1d

- Babies born during the measurement period to prenatal care patients

Numerator: Columns 1b + 1c

- Babies born with a birth weight below normal (under 2,500 grams)

Exclusions/Exceptions

- Denominator Exclusions
  - Stillbirths or miscarriages
- Denominator Exceptions
  - Not applicable

Specification Guidance

- Not applicable

UDS Reporting Considerations

- Report the total number of **live** births during the calendar year for patients who received prenatal care from the health center or a referral provider during the calendar year, according to the appropriate birth weight group (in grams):

- **Very Low Birth Weight (Column 1b):** Weight at birth was less than 1,500 grams.
- **Low Birth Weight (Column 1c):** Weight at birth was 1,500 grams through 2,499 grams.
- **Normal Birth Weight (Column 1d):** Weight at birth was equal to or greater than 2,500 grams.

Note: Be careful not to confuse pounds and ounces for grams when reporting these numbers. Include birth weight for neonatal demises.

- If the delivery is of multiple babies (e.g., twins or triplets), report the birth weight of each baby separately.
- Report data regardless of whether the health center did the delivery or referred the delivery to another provider, and regardless of whether the patient transferred to another provider on their own. **Tracking and follow-up on all prenatal care patients are required.**
- In rare instances, there may be no birth outcomes recorded although there may be evidence (i.e., records indicate delivery occurred) that the patient delivered. Report the patient as having delivered (Column 1a) with no birth outcomes (Columns 1b–1d).
- The number of deliveries reported in Column 1a will normally be different than the total number of babies reported in Columns 1b–1d because of multiple births and stillbirths.
- Although data are provided for each race and ethnicity category, the measure looks only at the totals.[31]

Note: This is a "negative" measure: The *higher* the proportion of infants born below normal birth weight, the worse the performance on the measure.

SECTIONS B AND C: OTHER HEALTH OUTCOME MEASURES

- Sections B and C specifically assess patients seen during the year for a UDS countable visit **AND** CQM qualifying encounter, as specified in the measure criteria (e.g., patients who had a visit reported on Table 5 at least once during the calendar year and who had a visit that meets the qualifying encounter specifications in a given measure).
- Patients seen only for care in an urgent care setting, patients seen only once for acute care, patients seen only for specialty care, and/or patients who have since left the practice are not to be excluded from the measures. Patients with a countable visit during the calendar year (reported anywhere on Table 5) and who meet the qualifying encounter criteria in the measure specifications are to be included.
- For measures requiring the completion of screenings, tests, or procedures to meet the numerator criteria, the findings of the screenings, test results, or procedures must be accessible in the patient health record.

Controlling High Blood Pressure (Columns 2a–2c), CMS165v12

Measure Description

Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

[31] However, during the review of the UDS Report, reviewers may question unusually high or low proportion of low-birth-weight babies for individual race or ethnicity categories.

Calculate as follows:

Denominator: Columns 2a and 2b

- Patients 18 through 85 years of age by the end of the measurement period who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first 6 months of the measurement period, with a qualifying encounter during the measurement period, as specified in the measure criteria
    - Include patients with birthdate on or after January 1, 1939, and birthdate on or before December 31, 2006.

Numerator: Column 2c

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
    - Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period
    - Patients with a diagnosis of pregnancy during the measurement period
    - Patients who were in hospice care for any part of the measurement period
    - Patients aged 66 or older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period
    - Patients aged 66–80 by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior
    - Patients 81 and older by the end of the measurement period with an indication of frailty for any part of the measurement period
    - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
    - Not applicable

Specification Guidance

- Only blood pressure readings performed by a provider or an automated blood pressure monitor or device are acceptable for the numerator criteria with this measure.
- Blood pressure readings are acceptable if:
    - taken in person by a clinician,
    - measured remotely by an electronic monitoring device capable of transmitting the blood pressure data to the clinician, or
    - taken by an **automated** blood pressure monitor or device and conveyed by the patient to the clinician. This is not considered patient self-reporting.
- It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's health record.

- If there are multiple blood pressure readings on the last day the patient was seen, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." Report them in Columns 2a and 2b, but NOT in Column 2c. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator CQM compliance.
- DO NOT include blood pressure readings taken during an acute inpatient stay or emergency department visit.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Include patients who have an active diagnosis of essential hypertension even if their qualifying encounter, as specified by the measure steward, during the year was unrelated to the diagnosis.
- Include blood pressure readings taken and documented in the patient's health record at any visit type by the health center as long as the result used for this measure is from the most recent calendar year visit.
- Although data are provided for each race and ethnicity category, the measure looks only at the totals.

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0 percent) (Columns 3a–3f), CMS122v12

Measure Description

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

Calculate as follows:

Denominator: Columns 3a and 3b

- Patients 18 through 75 years of age by the end of the measurement period with diabetes with a qualifying encounter during the measurement period, as specified in the measure criteria
  - Include patients with birthdate on or after January 1, 1949, and birthdate on or before December 31, 2006.

Numerator: Column 3f

- Patients whose most recent HbA1c level performed during the measurement period was greater than 9.0%, or was missing, or was not performed during the measurement period

Exclusions/Exceptions

- Denominator Exclusions
  - Patients who were in hospice care for any part of the measurement period
  - Patients aged 66 or older by the end of the measurement period who were living long-term in a nursing home any time on or before the end of the measurement period

  - Patients aged 66 or older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior
  - Patients who received palliative care for any part of the measurement period
- Denominator Exceptions
  - Not applicable

Specification Guidance

- If the HbA1c test result is in the patient health record, the test can be used to determine the numerator criteria.

UDS Reporting Considerations

- The patient must have a countable visit reported on Table 5 of the UDS Report in the measurement period to be included in this measure.
- Report patients who have an active diagnosis of diabetes even if their qualifying encounter, as specified by the measure steward, during the year was unrelated to the diagnosis.
- Use codes as outlined in the measure specifications to determine if diagnosis of secondary diabetes due to another condition is to be included.
- Include patients in the numerator whose most recent HbA1c level is greater than 9.0%, for whom the most recent HbA1c result is missing, or for whom no HbA1c tests were performed or documented during the measurement period. Patient self-report is NOT accepted.
- Even if the treatment of the patient's diabetes has been referred to a non–health center provider, the health center is expected to have the current lab test results in its records.
- Although data are provided for each race and ethnicity category, the measure looks only at the totals.

Note: This is a "negative" measure: The *lower* the number of adult patients with diabetes with poor diabetes control, the better the performance on the measure.

FAQ FOR TABLE 7

1. **When would we use Line h, "Unreported/Chose not to disclose" race and ethnicity?**

   Use Line h only in those instances where patients DO NOT provide their race **and** DO NOT state whether they are of Hispanic, Latino/a, or Spanish origin. Report patients who provide a race but DO NOT affirmatively answer a question about Hispanic, Latino/a, or Spanish ethnicity as Not Hispanic, Latino/a, or Spanish origin on the appropriate race line (Lines 2a–2g). Report patients who indicate they are Hispanic, Latino/a, or Spanish origin but DO NOT provide a race on Line 1g.

2. **Data are requested by race and Hispanic, Latino/a, or Spanish ethnicity. How are these to be coded?**

   Report race and Hispanic, Latino/a, or Spanish ethnicity on this table in the same manner used to report on Table 3B. Refer to instructions for Table 3B for further information describing race and ethnicity categories, including subcategories. Ensure the same information is recorded in both the patient health record and the registration form to avoid errors.

3. **Are patients with diabetes required to bring to the health center documentation of HbA1c tests received from outside the health center?**

   The health center is required to have HbA1c test results in patient health records. If the health center does not perform the test, contact the provider who performed the tests. The documentation can be brought in by the patient, but can also be obtained by fax, by requesting that the patient mail a copy of test results, or through other appropriate means.

4. **In Section A, Deliveries and Birth Outcomes, should the race and ethnicity of the baby be the same as that of the mother?**

   Not necessarily. Report the race and ethnicity of the mother (Column 1a) separately from that of the baby (Column 1b, 1c, or 1d). The baby's race and ethnicity may differ from the race and ethnicity of the mother.

5. **How do we report miscarriages and pregnancy terminations on this table?**

   You don't. Report all pregnant women in your prenatal care program (direct or by referral) on Table 6B but report only those patients who deliver on Table 7. Consider a stillbirth to be a delivery for purposes of reporting in Column 1a, but DO NOT report the baby by birth weight in Columns 1b, 1c, or 1d.

6. **How do we determine "active diagnosis" that is required for some measures?**

   Patient health records frequently contain a "problem list," a list of "active diagnoses," or lists by other names. Any diagnosis on the list for part or all of the calendar year is considered "active."

7. **Can we use our population health management system to report on the eCQMs?**

   Possibly. Health centers that have Office of the National Coordinator for Health Information Technology (ONC)-certified I2I-Track, personal computer dimensional measurement inspection software (PC-DMIS), a patient electronic care system (PECS), data reporting and analytics solutions (DRVS), population health management systems, or other supporting systems may use them to report the denominator only if it can be limited to the measurement period and only if it includes all required data elements (e.g., it includes data for the required time frame for all patients with hypertension from all service sites).

TABLE 7: HEALTH OUTCOMES

Calendar Year: January 1, 2024, through December 31, 2024

Section A: Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Women	
2	Deliveries Performed by Health Center's Providers	

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
	Mexican, Mexican American, Chicano/a				
1a1m	Asian Indian				
1a2m	Chinese				
1a3m	Filipino				
1a4m	Japanese				
1a5m	Korean				
1a6m	Vietnamese				
1a7m	Other Asian				
1b1m	Native Hawaiian				
1b2m	Other Pacific Islander				
1b3m	Guamanian or Chamorro				
1b4m	Samoan				
1cm	Black or African American				
1dm	American Indian/Alaska Native				
1em	White				
1fm	More than One Race				
1gm	Unreported/Chose Not to Disclose Race				
	Subtotal Mexican, Mexican American, Chicano/a	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Puerto Rican				
1a1p	Asian Indian				
1a2p	Chinese				
1a3p	Filipino				
1a4p	Japanese				
1a5p	Korean				
1a6p	Vietnamese				
1a7p	Other Asian				
1b1p	Native Hawaiian				
1b2p	Other Pacific Islander				
1b3p	Guamanian or Chamorro				

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
1b4p	Samoan				
1cp	Black or African American				
1dp	American Indian/Alaska Native				
1ep	White				
1fp	More than One Race				
1gp	Unreported/Chose Not to Disclose Race				
	Subtotal Puerto Rican	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Cuban				
1a1c	Asian Indian				
1a2c	Chinese				
1a3c	Filipino				
1a4c	Japanese				
1a5c	Korean				
1a6c	Vietnamese				
1a7c	Other Asian				
1b1c	Native Hawaiian				
1b2c	Other Pacific Islander				
1b3c	Guamanian or Chamorro				
1b4c	Samoan				
1cc	Black or African American				
1dc	American Indian/Alaska Native				
1ec	White				
1fc	More than One Race				
1gc	Unreported/Chose Not to Disclose Race				
	Subtotal Cuban	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Another Hispanic, Latino/a, or Spanish Origin				
1a1a	Asian Indian				
1a2a	Chinese				
1a3a	Filipino				
1a4a	Japanese				
1a5a	Korean				
1a6a	Vietnamese				
1a7a	Other Asian				
1b1a	Native Hawaiian				
1b2a	Other Pacific Islander				

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
1b3a	Guamanian or Chamorro				
1b4a	Samoan				
1ca	Black or African American				
1da	American Indian/Alaska Native				
1ea	White				
1fa	More than One Race				
1ga	Unreported/Chose Not to Disclose Race				
	Subtotal Another Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Hispanic, Latino/a, or Spanish Origin Combined				
1a1o	Asian Indian				
1a2o	Chinese				
1a3o	Filipino				
1a4o	Japanese				
1a5o	Korean				
1a6o	Vietnamese				
1a7o	Other Asian				
1b1o	Native Hawaiian				
1b2o	Other Pacific Islander				
1b3o	Guamanian or Chamorro				
1b4o	Samoan				
1co	Black or African American				
1do	American Indian/Alaska Native				
1eo	White				
1fo	More than One Race				
1go	Unreported/Chose Not to Disclose Race				
	Subtotal Hispanic, Latino/a, or Spanish Origin, Combined	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Total Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Not Hispanic, Latino/a, or Spanish Origin				
2a1	Asian Indian				
2a2	Chinese				
2a3	Filipino				
2a4	Japanese				
2a5	Korean				
2a6	Vietnamese				
2a7	Other Asian				

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500–2499 grams (1c)	Live Births: ≥2500 grams (1d)
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2b3	Guamanian or Chamorro				
2b4	Samoan				
2c	Black or African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Chose Not to Disclose Race				
	Total Not Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>	<cell not reported>
	Unreported/Chose Not to Disclose Race and Ethnicity				
h	Unreported/Chose Not to Disclose Race and Ethnicity				
i	**Total**				

Section B: Controlling High Blood Pressure

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number of Records Reviewed (2b)	Patients with Hypertension Controlled (2c)
	Mexican, Mexican American, Chicano/a			
1a1m	Asian Indian			
1a2m	Chinese			
1a3m	Filipino			
1a4m	Japanese			
1a5m	Korean			
1a6m	Vietnamese			
1a7m	Other Asian			
1b1m	Native Hawaiian			
1b2m	Other Pacific Islander			
1b3m	Guamanian or Chamorro			
1b4m	Samoan			
1cm	Black or African American			
1dm	American Indian/Alaska Native			
1em	White			
1fm	More than One Race			
1gm	Unreported/Chose Not to Disclose Race			
	Subtotal Mexican, Mexican American, Chicano/a	<cell not reported>	<cell not reported>	<cell not reported>
	Puerto Rican			
1a1p	Asian Indian			
1a2p	Chinese			
1a3p	Filipino			
1a4p	Japanese			
1a5p	Korean			
1a6p	Vietnamese			
1a7p	Other Asian			
1b1p	Native Hawaiian			
1b2p	Other Pacific Islander			
1b3p	Guamanian or Chamorro			
1b4p	Samoan			
1cp	Black or African American			
1dp	American Indian/Alaska Native			

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number of Records Reviewed (2b)	Patients with Hypertension Controlled (2c)
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican	<cell not reported>	<cell not reported>	<cell not reported>
	Cuban			
1a1c	Asian Indian			
1a2c	Chinese			
1a3c	Filipino			
1a4c	Japanese			
1a5c	Korean			
1a6c	Vietnamese			
1a7c	Other Asian			
1b1c	Native Hawaiian			
1b2c	Other Pacific Islander			
1b3c	Guamanian or Chamorro			
1b4c	Samoan			
1cc	Black or African American			
1dc	American Indian/Alaska Native			
1ec	White			
1fc	More than One Race			
1gc	Unreported/Chose Not to Disclose Race			
	Subtotal Cuban	<cell not reported>	<cell not reported>	<cell not reported>
	Another Hispanic, Latino/a, or Spanish Origin			
1a1a	Asian Indian			
1a2a	Chinese			
1a3a	Filipino			
1a4a	Japanese			
1a5a	Korean			
1a6a	Vietnamese			
1a7a	Other Asian			
1b1a	Native Hawaiian			
1b2a	Other Pacific Islander			
1b3a	Guamanian or Chamorro			
1b4a	Samoan			
1ca	Black or African American			

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number of Records Reviewed (2b)	Patients with Hypertension Controlled (2c)
1da	American Indian/Alaska Native			
1ea	White			
1fa	More than One Race			
1ga	Unreported/Chose Not to Disclose Race			
	Subtotal Another Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Hispanic, Latino/a, or Spanish Origin, Combined			
1a1o	Asian Indian			
1a2o	Chinese			
1a3o	Filipino			
1a4o	Japanese			
1a5o	Korean			
1a6o	Vietnamese			
1a7o	Other Asian			
1b1o	Native Hawaiian			
1b2o	Other Pacific Islander			
1b3o	Guamanian or Chamorro			
1b4o	Samoan			
1co	Black or African American			
1do	American Indian/Alaska Native			
1eo	White			
1fo	More than One Race			
1go	Unreported/Chose Not to Disclose Race			
	Subtotal Hispanic, Latino/a, or Spanish Origin, Combined	<cell not reported>	<cell not reported>	<cell not reported>
	Total Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Not Hispanic, Latino/a, or Spanish Origin			
2a1	Asian Indian			
2a2	Chinese			
2a3	Filipino			
2a4	Japanese			
2a5	Korean			
2a6	Vietnamese			

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number of Records Reviewed (2b)	Patients with Hypertension Controlled (2c)
2a7	Other Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2b3	Guamanian or Chamorro			
2b4	Samoan			
2c	Black or African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Chose Not to Disclose Race			
	Total Not Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Unreported/Chose Not to Disclose Race and Ethnicity			
h	Unreported/Chose Not to Disclose Race and Ethnicity			
i	**Total**			

Section C: Diabetes: Hemoglobin A1c Poor Control

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number of Records Reviewed (3b)	Patients with HbA1c >9.0% or No Test During Year (3f)
	Mexican, Mexican American, Chicano/a			
1a1m	Asian Indian			
1a2m	Chinese			
1a3m	Filipino			
1a4m	Japanese			
1a5m	Korean			
1a6m	Vietnamese			
1a7m	Other Asian			
1b1m	Native Hawaiian			
1b2m	Other Pacific Islander			
1b3m	Guamanian or Chamorro			
1b4m	Samoan			
1cm	Black or African American			
1dm	American Indian/Alaska Native			
1em	White			
1fm	More than One Race			
1gm	Unreported/Chose Not to Disclose Race			
	Subtotal Mexican, Mexican American, Chicano/a	<cell not reported>	<cell not reported>	<cell not reported>
	Puerto Rican			
1a1p	Asian Indian			
1a2p	Chinese			
1a3p	Filipino			
1a4p	Japanese			
1a5p	Korean			
1a6p	Vietnamese			
1a7p	Other Asian			
1b1p	Native Hawaiian			
1b2p	Other Pacific Islander			
1b3p	Guamanian or Chamorro			
1b4p	Samoan			
1cp	Black or African American			
1dp	American Indian/Alaska Native			

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number of Records Reviewed (3b)	Patients with HbA1c >9.0% or No Test During Year (3f)
1ep	White			
1fp	More than One Race			
1gp	Unreported/Chose Not to Disclose Race			
	Subtotal Puerto Rican	<cell not reported>	<cell not reported>	<cell not reported>
	Cuban			
1a1c	Asian Indian			
1a2c	Chinese			
1a3c	Filipino			
1a4c	Japanese			
1a5c	Korean			
1a6c	Vietnamese			
1a7c	Other Asian			
1b1c	Native Hawaiian			
1b2c	Other Pacific Islander			
1b3c	Guamanian or Chamorro			
1b4c	Samoan			
1cc	Black or African American			
1dc	American Indian/Alaska Native			
1ec	White			
1fc	More than One Race			
1gc	Unreported/Chose Not to Disclose Race			
	Subtotal Cuban	<cell not reported>	<cell not reported>	<cell not reported>
	Another Hispanic, Latino/a, or Spanish Origin			
1a1a	Asian Indian			
1a2a	Chinese			
1a3a	Filipino			
1a4a	Japanese			
1a5a	Korean			
1a6a	Vietnamese			
1a7a	Other Asian			
1b1a	Native Hawaiian			
1b2a	Other Pacific Islander			
1b3a	Guamanian or Chamorro			
1b4a	Samoan			
1ca	Black or African American			

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number of Records Reviewed (3b)	Patients with HbA1c >9.0% or No Test During Year (3f)
1da	American Indian/Alaska Native			
1ea	White			
1fa	More than One Race			
1ga	Unreported/Chose Not to Disclose Race			
	Subtotal Another Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Hispanic, Latino/a, or Spanish Origin, Combined			
1a1o	Asian Indian			
1a2o	Chinese			
1a3o	Filipino			
1a4o	Japanese			
1a5o	Korean			
1a6o	Vietnamese			
1a7o	Other Asian			
1b1o	Native Hawaiian			
1b2o	Other Pacific Islander			
1b3o	Guamanian or Chamorro			
1b4o	Samoan			
1co	Black or African American			
1do	American Indian/Alaska Native			
1eo	White			
1fo	More than One Race			
1go	Unreported/Chose Not to Disclose Race			
	Subtotal Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Total Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Not Hispanic, Latino/a, or Spanish Origin			
2a1	Asian Indian			
2a2	Chinese			
2a3	Filipino			
2a4	Japanese			
2a5	Korean			
2a6	Vietnamese			

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number of Records Reviewed (3b)	Patients with HbA1c >9.0% or No Test During Year (3f)
2a7	Other Asian			
2b1	Native Hawaiian			
2b2	Other Pacific Islander			
2b3	Guamanian or Chamorro			
2b4	Samoan			
2c	Black or African American			
2d	American Indian/Alaska Native			
2e	White			
2f	More than One Race			
2g	Unreported/Chose Not to Disclose Race			
	Total Not Hispanic, Latino/a, or Spanish Origin	<cell not reported>	<cell not reported>	<cell not reported>
	Unreported/Chose Not to Disclose Race and Ethnicity			
h	Unreported/Chose Not to Disclose Race and Ethnicity			
i	**Total**			

Table 7 Cross-Table Considerations:

- Patients with countable visits on Table 5 are generally eligible for inclusion in eCQMs reported on Table 7.
- The relationship between the denominators on Table 7 should be verified as reasonable when compared to the total number of patients by age on Table 3A and patients by race and ethnicity on Table 3B.
- The count of patients by diagnosis reported on Table 6A will not be the same counts as on Table 7, due to differences in criteria that must be met for inclusion on Table 7.

Instructions for Table 8A: Financial Costs

Table 8A collects the total cost of all activities attributable to the calendar year that are within the approved scope of project. Total costs include all costs within the health center scope of project, regardless of source of funding (e.g., the Health Center Program award, patient and third-party payments, other grants and contracts). Thus, Table 8A describes what it costs to operate the health center's approved scope of project.

There are no major changes to this table.

TABLE 8A: FINANCIAL COSTS – INSTRUCTIONS

This table provides **accrued** costs and allocation of facility and non-clinical support services by cost center.

COLUMN REPORTING REQUIREMENTS

This table is made up of three columns: Accrued Costs (Column A), Allocation of Facility and Non-Clinical Support Services (Column B), and the Total Cost after Allocation (Column C).

- Report the costs accrued in the calendar year, including depreciation, regardless of when (or, in the case of donations on Line 18, if) actual cash payments were made.
- Report only the depreciation on capital assets, including those acquired with HRSA's BPHC grants, NOT the full cost.
- Report interest payments on loans as an expense.
- DO NOT report bad debt expense or the repayment of the principal of a loan. These are not reported anywhere in the UDS Report.

Note: A table summarizing the cost columns is included in FAQ for Table 8A.

Column A: Accrued Costs

- Report the accrued costs in U.S. dollars (USD) associated with each of the service delivery cost centers listed. See Line Definitions for costs to include in each category.
- Report the total facility cost and the total cost of non-clinical support services (also referred to as administrative costs) separately on Lines 14 and 15.

Column B: Allocation of Facility Costs and Non-Clinical Support Service Costs

- Report the allocation of facility and non-clinical support services costs (USD) (from Lines 14 and 15, Column A) to each of the cost centers. See Allocation Methods at the end of the instructions for this table for guidance on allocating facility and non-clinical support service costs.

Column C: Total Cost After Allocation of Facility and Non-Clinical Support Services

- Report the cost (USD) of each of the cost centers listed on Lines 1–13.
- This cost is the sum of the direct cost, reported in Column A, plus the allocation of facility and non-clinical support services costs, reported in Column B.

Note: All UDS calculations involving total cost, such as total costs per patient, are based on Line 17 and DO NOT include the value of donated services, supplies, or facilities reported on Line 18.

COST CENTER LINE REPORTING REQUIREMENTS

- Align costs reported on Table 8A with FTEs and services reported on Table 5. A crosswalk that classifies personnel for various cost line items is available in Appendix B.
- If an individual's FTE is split across multiple lines on Table 5, the same proportional allocation must be used for that individual's personnel costs on this table.

Medical Personnel Costs (Line 1)

- Report all medical personnel costs, including salaries and fringe benefits for medical care personnel reported on Table 5, Lines 1–12, including costs for personnel and contracted individuals.
- Include costs of medical interns and residents who were paid directly or under a contract with their teaching institution.
- Report vouchered or contracted medical services, including the cost of any medical visit paid for directly by the health center, such as at-risk specialty care from a managed care organization (MCO) contract or other specialty care.
- Report the amount of Promoting Interoperability Programs and any EHR incentive payments the health center permits the provider to retain. (Also, report all Promoting Interoperability Programs EHR incentive payments received during the calendar year from Medicare or Medicaid as cash receipts on Table 9E, Line 3a.) DO NOT report the Promoting Interoperability Programs EHR incentive payments retained by the health center on this table.
- Include costs for medical activities by medical personnel even when they are not directly providing care to patients, such as chairing or attending meetings, supervising personnel, writing clinical protocols, designing formularies, setting hours, or approving specialty referrals. The exception to this rule is when a medical director or chief medical officer is engaged in non-clinical activities at the **corporate level**, in which case time and costs are allocated to the non-clinical category.
- DO NOT report the costs of medical lab and X-ray personnel (report on Line 2) or dedicated health IT/EHR informatics and QI personnel (report on Line 12a).
- DO NOT report the costs of intake, patient health records, and billing and collections, as these are considered non-clinical support costs (report on Line 15).

Medical Lab and X-Ray Costs (Line 2)

- Report all costs for the provision of medical lab and X-ray services and personnel reported on Table 5, Lines 13 and 14 (including sonography, mammography, and any advanced forms of tomography), including salaries and fringe benefits provided directly or under contract.
- DO NOT include other direct medical costs, including but not limited to medical supplies, equipment depreciation, and related travel (report on Line 3).
- DO NOT include dental lab and X-ray costs (report as Dental, Line 5).
- DO NOT include costs for retinography readings by specialists (most commonly for diabetic patients) (report as Vision Services, Line 9a).

Other Direct Medical Costs (Line 3)

- Report all non-personnel direct costs for medical care, including but not limited to supplies, equipment depreciation, related travel, medical education expense not including fringe benefits (which are reported on Line 1), meeting registration and travel, uniform laundering, recruitment, membership in professional societies, books, and journal subscriptions.
- Report the cost of the medical aspects of a health IT/EHR system, including but not limited to the depreciation of software and hardware, training costs, and licensing fees. If the health IT/EHR system is used in other service categories (e.g., mental health, dental), allocate costs to each of the services in which it is used.
- DO NOT report non-clinical support services and facility costs associated with these cost centers (report on Lines 14 and 15, Column A, and then allocate them to the cost center in Column B). (See also FAQ for Table 5.)

Total Medical (Line 4)

Sum Lines 1 + 2 + 3.

Other Clinical Services (Lines 5–10)

This category includes personnel and related costs for dental, mental health, substance use disorder, pharmacy, vision, and services rendered by other professional personnel (e.g., chiropractors, naturopaths, occupational and physical therapists, speech and hearing therapists, podiatrists). Unlike medical, all costs are included on a single line.

- Report all direct costs for the provision of services in the listed service area, including but not limited to personnel, fringe benefits, training, contracted services, office supplies, equipment depreciation, related travel, health IT/EHR, lab services, and X-ray.
- DO NOT report non-clinical support services and facility costs associated with these cost centers (report on Lines 14 and 15, Column A, and then allocate them to the cost center in Column B). (See also FAQ for Table 5.)

Dental (Line 5)

- Report all direct costs for the provision of dental services reported on Table 5, Lines 16–18.

Mental Health (Line 6)

- Report all direct costs for the provision of mental health services reported on Table 5, Lines 20a–20c, other than substance use disorder services.
- If a behavioral health program provides both mental health and substance use disorder services, the cost should be allocated between the two services. Allocations must align with FTEs and visits reported on Table 5. DO NOT make any allocations based on the detail reported on the Selected Service Detail Addendum.

Substance Use Disorders (Line 7)

- Report all direct costs for the provision of substance use disorder services reported on Table 5, Line 20.
- If a behavioral health program provides both mental health and substance use disorder services, the cost should be allocated between the two services. Allocations must align with FTEs and visits reported on Table 5.
- DO NOT make any allocations based on the detail reported on the Selected Service Detail Addendum.

Pharmacy (Not Including Pharmaceuticals) (Line 8a)

- Report all direct costs for the provision of pharmacy services reported on Table 5, Lines 23a–23d.
- If 340B drugs are purchased by or on behalf of a clinic and dispensed by a contract pharmacy, report the full dispensing fees and any other service fees (such as "share of profit," pharmacy benefit manager costs, inventory fees, ordering fees, administrative fees, or a charge for pharmacy computer services) on this line, regardless of whether the health center pays the full amount, pays a net after subtraction of revenue at the contract pharmacy, or simply receives a reduced net payment from the pharmacy.
- DO NOT include the cost of pharmaceuticals (report on Line 8b).
- DO NOT report the cost of personnel engaged in assisting patients to become eligible for free pharmaceuticals from manufacturers (often called PAPs) (report as Eligibility Assistance on Line 11e).

Pharmaceuticals (Line 8b)

- Report all costs for the purchase of pharmaceuticals only.
- Include vaccines and medications administered at the health center (e.g., penicillin, Depo-Provera, buprenorphine).
- Report the full cost of 340B drugs purchased by or on behalf of the clinic and dispensed by a contract pharmacy. This includes 340B drugs paid for in full by the health center, as well as the full cost of drugs paid for through an agreement whereby the pharmacy initially pays for the drugs and then deducts the cost from their receipts.
- DO NOT include other supplies here (report on Line 8a, Pharmacy).
- DO NOT include the value of donated pharmaceuticals (report on Line 18, Column C).

Note: Allocation of Facility and Non-Clinical Support Services, Column B, is grayed out on Pharmaceuticals, Line 8b. Report total overhead costs for pharmaceuticals on Line 8a, Pharmacy.

Other Professional (Line 9)

- Report all direct costs for the provision of other professional and ancillary health care services reported on Table 5, Line 22, including but not limited to, podiatry, chiropractic, acupuncture, naturopathy, speech and hearing pathology, or occupational and physical therapy. (A more complete list appears in Appendix A.)
- DO NOT report the cost of WIC, the Program of All-Inclusive Care for the Elderly (PACE), or ADHC here (report on Line 12, Other Program-Related).

Note: Use the "specify" field to detail the other professional costs reported on this line.

Vision (Line 9a)

- Report all direct costs for the provision of vision services reported on Table 5, Lines 22a–22c, including optometry, ophthalmology, and vision support personnel.
- Include the cost of frames and lenses.
- Include costs for retinography (including for diabetic patients) and any contracted costs for reading the results.

Total Other Clinical (Line 10)

Sum of Lines 5 + 6 + 7 + 8a + 8b + 9a.

Enabling (Lines 11a–11h, 11)

Enabling services include a wide range of services that support and assist primary care and facilitate patient access to care. Report all direct costs for the provision of enabling services reported on Table 5, Lines 24–28, including salary, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

- Report enabling services by function. Use Lines 11a–11h to detail the cost of seven specific types of enabling services and an "other" category for all other forms of enabling services.
  - Case management (11a)
  - Transportation (11b)
  - Outreach (11c)
  - Health education (11d)
  - Eligibility assistance (includes assistance in obtaining program eligibility, including PAP and health insurance coverage options) (11e)
  - Translation/interpretation services (11f)
  - Other (specify the other forms of enabling services included on this line if used) (11g)
  - Community health workers (11h)
- The enabling services personnel costs reported (for Lines 11a and 11d) must be consistent with the FTEs and visits reported on Table 5.

Note: Descriptions of the services and personnel that belong in each of these categories are included in the Instructions for Table 5 and in Appendix A.

Note: The overhead to be allocated to all enabling service categories is reported in Column B on Line 11, Total Enabling Services. Allocation of Facility and Non-Clinical Support Services, Column B, is grayed out for all other enabling service categories.

Total Enabling Services (Line 11)

Sum of Lines 11a + 11b + 11c + 11d + 11e + 11f + 11g + 11h.

Other Program-Related (Line 12)

- Report costs of all in-scope items and programs not classifiable as medical, dental, behavioral, vision, enabling, or other professional health services (Lines 1–11).
- Include programs and items such as WIC, child care centers, ADHC centers, fitness centers, Head Start and Early Head Start, housing, clinical trials, research, employment training, the cost of space, staff, and other items leased to others, retail pharmacy services provided to non–health center patients, the amount of grant funds passed through to other agencies if patient activity is not included in the health center's reporting, and similar activities.
- Report salaries, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.

- Report the estimated cost of facilities, programs, or services that may be part of the health center scope of project but are not tied to health center patient activity. Examples might include renting out space in the health center or providing retail pharmacy services to non-patient members of the community.
- Describe the programs and their costs using the "specify" field provided. The program descriptions should correspond to the "specify" field on Table 5, Line 29a, where FTE are reported.

Quality Improvement (QI) (Line 12a)

- Report all direct costs for the health center's QI program reported on Table 5, Line 29b, including all personnel who are dedicated in whole or in part to QI.
- Include the costs of personnel dedicated to the QI program and/or health IT/EHR system development and analysis, their fringe benefits, supplies, equipment depreciation, related travel, and contracted services.
- DO NOT allocate portions of the time and cost that QI personnel spend attending meetings, participating in peer review, designing or interpreting QI findings, and so on to other service categories.

Total Enabling, Other Program-Related, and Quality Improvement Services (Line 13)

Sum of Lines 11 + 12 +12a.

Facility Costs (Line 14)

- Report costs associated with FTE reported on Table 5, Line 31, including all personnel dedicated to facility services and their fringe benefits, as well as supplies, equipment depreciation, related travel, and contracted services.
- Include rent and/or depreciation (not asset acquisition cost) of facilities and mobile units, facility mortgage interest (but not principal) payments, utilities, security, grounds keeping, facility maintenance and repairs, janitorial services, and all other related costs.
- DO NOT report the cost of space leased to others on this line. Instead, report it as Other Program-Related costs on Line 12. The receipts associated with these leases are reported on Table 9E, Line 10.

Note: Allocation of Facility and Non-Clinical Support Services, Column B, and Total Cost After Allocation of Facility and Non-Clinical Support Services, Column C, are grayed out for Facility Costs, Line 14.

Non-Clinical Support Services Costs (Line 15)

- Report non-clinical support services costs (sometimes referred to as administrative costs) associated with the personnel reported on Table 5, Lines 30a–30c and 32, including the cost of all non-clinical support services personnel, senior administrative personnel (CEO, CFO, COO, HR director, et al.), billing and collections personnel, patient health records and intake personnel, and the costs associated with them. Include the portion of the medical directors or other personnel costs dedicated to corporate management activities.
- Include salaries, fringe benefits, supplies, equipment depreciation, related travel, and contracted services.
- Report corporate costs (e.g., purchase of facility and liability insurance, not including malpractice insurance, audits, legal fees, interest payments on non-facility loans, and communication costs including phone and internet).
- Report costs attributable to the board of directors, including travel expenses, meetings, directors' and officers' insurance, conference registration fees, and similar expenses.

- Some grant programs limit the proportion of grant funds that may be used for non-clinical support services. DO NOT consider those limits on "administrative" costs for those programs when completing Lines 14 and 15. The non-clinical support services and facility categories for this report include all such personnel working at the health center, whether or not that cost was includable or considered "administrative" in a grant budget.
- DO NOT report bad debt expenses for patient services here or anywhere on this table. Report self-pay bad debt as an adjustment to patient self-pay charges on Table 9D, Line 13.

Note: Allocation of Facility and Non-Clinical Support Services, Column B, and Total Cost After Allocation of Facility and Non-Clinical Support Services, Column C, are grayed out for Non-Clinical Support Services Costs, Line 15.

Total Facility and Non-Clinical Support Services (Line 16)

Sum of Lines 14 + 15.

Note: Since the direct facility and non-clinical support cost in Column A is allocated to the other cost centers, nothing is reported in Columns B or C on Lines 14–16. These fields are grayed out.

Total Accrued Costs (Line 17)[32]

Sum of Lines 4 + 10 + 13 + 16.

Note: Allocation of Facility and Non-Clinical Support Services, Column B, is grayed out for Total Accrued Costs, Line 17.

Value of Donated Facilities, Services, and Supplies (Line 18, Column C)

- Report the total imputed (assigned) value of all in-kind and donated services, facilities, and supplies that are necessary to the health center's operation applicable to the calendar year and within your scope of project as follows.
- Report the estimated reasonable acquisition cost of donated personnel, supplies, services, space rental, and estimated depreciation for the use of donated equipment.
- Report donated pharmaceuticals (including vaccines) at the price that would be paid under the federal Section 340B Drug Pricing Program, NOT the manufacturer's suggested retail price.
- Estimate reasonable acquisition cost of donated personnel at the cost of hiring comparable personnel.
- If the health center is not paying NHSC for assignees, include the full market value of NHSC federal assignee(s), including "ready responders." Capitalize NHSC-furnished equipment, including a dental operatory, at the amount reported on the NHSC Equipment Inventory Document, and report the appropriate depreciation expense for the calendar year.
- Use the "specify" field provided to describe the donated items and amounts in detail.
- DO NOT include the value of donations in Column A on the lines above.
- DO NOT use the sum of the usual and customary charges rendered by providers who donate their services to value their donation.

[32] This is the amount used in the HRSA's BPHC calculation of measures involving total cost.

Note: Accrued Cost, Column A, and Allocation of Facility and Non-Clinical Support Services, Column B, are grayed out for Value of Donated Facilities, Services, and Supplies, Line 18.

Total with Donations (Line 19)

Sum of Lines 17 + 18, Column C.

Note: Accrued Cost, Column A, and Allocation of Facility and Non-Clinical Support Services, Column B, are grayed out for Total with Donations, Line 19.

COLUMN B: FACILITY AND NON-CLINICAL SUPPORT SERVICES ALLOCATION INSTRUCTIONS

There are multiple ways that facility and non-clinical support services (Lines 14 and 15, Column A) may be allocated to the cost centers in Column B (Lines 1–13).

- Use the simplest method that produces a reasonably accurate result that is comparable to that obtained by a more complex method. Use the method described below if a more accurate method is not available.
- It is recommended that facility and non-clinical support costs that can be directly associated to a cost center be allocated first when those costs represent a significant portion of the cost being allocated to the cost center. For instance, the facility and non-clinical support costs of a service delivery site that only provides dental services can be directly allocated in Column B to Dental, Line 5. The health IT/EHR support personnel who support the medical department can be directly allocated in Column B to Medical, Line 1.
- The remaining allocation of indirect costs can be done using a single- or multi-step allocation process such as those described below.
- A preferable and commonly used two-step method is to first allocate facility costs based upon the proportion of square feet used by each cost center at each location. The second step is to allocate the remaining non-clinical support service cost based upon the percentage of direct cost that is non-clinical support, after the allocation of facility cost is applied.
- Given that managing personnel consumes most of administrative overhead, a one-step method based solely on the percentage distribution of square feet will usually NOT produce an accurate allocation of overhead.
- When a two-step method is not used, a typical one-step method uses the proportion of facility and non-clinical support costs (overhead costs) to total direct cost (excluding facility, non-clinical support, and pharmaceuticals). The resulting percentage is multiplied by the total direct cost for each cost center to arrive at the overhead allocation for each cost center.

Facility

Facility cost is commonly allocated based upon the proportion of square feet used by each cost center at each location.

Note: The record of square feet used by each cost center at each location should be updated each year or as space use changes.

Non-Clinical Support Services

Some of the indirect non-clinical support costs may be allocated separately based on known use or other factors.

- Adjust for decentralized front desk personnel, billing and collection systems and personnel, etc.
- Allocate costs for billing and accounting systems based on use.

- Allocate various components of non-clinical services based on their use when these amounts are significant, and the use is not shared equally.
- Allocate a lesser percentage to large purchased-service costs (e.g., lab, X-ray, pharmacy) that are known to consume less overhead.
- Allocate the remaining indirect non-clinical support cost to each cost center based on the proportion each cost center's direct cost plus previously allocated overhead cost is of the total of those costs.

Other Allocation Considerations

- Lines 1 and 3 both refer to aspects of the medical practice. It is acceptable to report the allocation of all medical facility and non-clinical support services on Line 1 if a more appropriate allocation between Lines 1 and 3 is not available.
- Pharmaceuticals (Line 8b) does not have an open cell to report an allocation. This is because pharmaceuticals are exclusively purchased goods that have no personnel and minimal space costs included and, therefore, consume a significantly lesser facility and non-clinical support charge than services involving personnel. Any allocation of overhead (which is usually minimal) that you choose to make for pharmaceuticals must be reported on Line 8a.
- There may be other sizable contracted or purchased goods and services that use less facility and non-clinical support. A lesser allocation may be appropriate.

FAQ FOR TABLE 8A

1. **How do we account for donated services?**

   If a provider *comes to your health center* and renders a service to your patients, report both the FTE (on Table 5) and the value, which is determined by "what the health center would reasonably pay" for the time (not the service), on Table 8A, Line 18. For example, if an optometrist sees five patients in a 2-hour period, report the amount you would pay an optometrist for 2 hours of work, not the total charges for the five visits.

   However, if you *refer a patient to a provider outside of your health center* for a service and the provider donates these services, DO NOT report the activity, the charge, or the value of the time or service on the UDS. This is outside of the health center's scope of project and is considered a donation made by the external provider to the patient. For example, if you refer a patient to a cardiologist who provides free consultation, DO NOT count the visit or the monetary value of the provider's service.

2. **How do we account for donated drugs?**

   If drugs are donated directly to the health center, which then dispenses them to a patient, calculate and report on Line 18 the value of the drug at what the health center would reasonably pay for them. This is NOT the retail cost of the drug; it is the 340B price of the drug—an amount that is generally 40–60% of the average wholesale price (AWP).

3. **We get most of our vaccines through Vaccines for Children (VFC) or other state and county programs. Are these considered donated drugs and accounted for here?**

   Yes. Report the value of donated drugs that are used in the health center, such as vaccines, on Line 18 in Table 8A—again, at the reasonable cost based on 340B drug pricing or at a discounted price from the AWP.

4. **Our doctors were paid the EHR incentive payments directly by CMS. If we let them keep some or all of these dollars, are they reported anywhere on Table 8A?**

Yes. Establish reporting mechanisms whereby your providers inform you of payments received and account for these funds. If providers are permitted to retain some or all these funds, report the amount as additional provider compensation on Line 1. In addition, report the Promoting Interoperability EHR payments received from Medicare or Medicaid on Table 9E, Line 3a.

5. What method of overhead (facility and non-clinical support services) allocation should we use for this table?

There are multiple ways that facility and non-clinical support services may be allocated to the cost centers in Column B. Use the method that produces a reasonably accurate result. See the suggested single- and multi-step allocation methods for additional information on these methods.

6. Do we need to allocate overhead for purchased goods and services?

Purchased (contracted) services DO NOT warrant a full overhead charge, given that they DO NOT involve the management of personnel. However, the procurement and supervision of those arrangements do consume overhead that should be reported. Assuming the amount of purchased services are significant, a lesser overhead allocation set at a rate that covers the cost of accounting, inventory management, and contract management is appropriate.

7. Why do our financial statements NOT tie to the UDS financials?

The UDS financials (Tables 8A, 9D, and 9E) will NOT tie to your financial statements for some or all of the following reasons:

(1) The UDS Report is to reflect calendar year January 1–December 31 data, but the health center's fiscal year may be a different period.

(2) Activity outside the scope of the federal project is included in the health center's financial statements but excluded in the UDS.

(3) Net patient service revenue that could be estimated from table 9D (charges less adjustments) may differ from the financial statements because the UDS only reports self-pay bad debt rather than the full adjustment for bad debt attributable to all payers and circumstances.

(4) Settlement and wrap revenue is only reported in the UDS upon its receipt, and health centers may be able to recognize and report some or all of the revenue on an accrual basis in the period it is earned.

(5) Table 9E reports all non–patient service-related revenue on a cash basis, and health centers will recognize this revenue on an accrual basis in their financial statements.

8. What do we need to report in the different columns of this table?

The column definitions are detailed on Table 8A. Below is a summary of what to include in each column.

Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
Costs attributable to the calendar year by cost center. Report costs of: • personnel • fringe benefits • supplies • equipment • depreciation • interest paid • related travel Exclude bad debt and repayment of principal on loans.	Allocation of facility and non-clinical support services (Column A, Lines 14 and 15) to each cost center. **Note:** Total of Column B must be equal to Column A, Line 16.	Represents cost to operate services. **Note:** Sum of Columns A + B (done automatically in EHBs).

9. How are awardee-subrecipient and contractor relationships to be reported?

Report the total cost of subawardee project operations in the UDS Report of the awarded health center that provided a subaward to the other health center (subawardee). If the subawardee is also a Health Center Program awardee, the subawardee will also report this activity on its UDS.

Activity associated with contracts for services purchased by one health center and provided by another health center will be reported in the UDS Report of both health centers. The health center providing the services reports the costs and activity of the services provided. The health center purchasing the services reports the cost and the activity of the services purchased.

10. How do we report the cost of shared or common space?

All facility costs, including the cost of common space, are included and reported on Line 14, Facility, in Column A, Accrued Costs.

11. How do we report the cost of space, staff, or other items that the health center leased or donated to others?

The cost of space, staff, and other items leased or donated by the health center to others is reported on Line 12, Other Program-Related Services.

TABLE 8A: FINANCIAL COSTS

Calendar Year: January 1, 2024, through December 31, 2024

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Financial Costs of Medical Care			
1	Medical Personnel			
2	Lab and X-ray			
3	Medical/Other Direct			
4	**Total Medical Care Services** (Sum of Lines 1 through 3)			
	Financial Costs of Other Clinical Services			
5	Dental			
6	Mental Health			
7	Substance Use Disorder			
8a	Pharmacy (not including pharmaceuticals)			
8b	Pharmaceuticals		[Cell not reported]	
9	Other Professional (specify___)			
9a	Vision			
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)			
	Financial Costs of Enabling and Other Services			
11a	Case Management		[Cell not reported]	
11b	Transportation		[Cell not reported]	
11c	Outreach		[Cell not reported]	
11d	Health Education		[Cell not reported]	
11e	Eligibility Assistance		[Cell not reported]	
11f	Interpretation Services		[Cell not reported]	
11g	Other Enabling Services (specify___)		[Cell not reported]	
11h	Community Health Workers		[Cell not reported]	
11	**Total Enabling Services** (Sum of Lines 11a through 11h)			
12	Other Program-Related Services (specify___)			
12a	Quality Improvement			
13	**Total Enabling and Other Services** (Sum of Lines 11, 12, and 12a)			

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
	Facility and Non-Clinical Support Services and Totals			
14	Facility		[Cell not reported]	[Cell not reported]
15	Non-Clinical Support Services		[Cell not reported]	[Cell not reported]
16	**Total Facility and Non-Clinical Support Services** (Sum of Lines 14 and 15)		[Cell not reported]	[Cell not reported]
17	**Total Accrued Costs** (Sum of Lines 4 + 10 + 13 + 16)		[Cell not reported]	
18	Value of Donated Facilities, Services, and Supplies (specify___)	[Cell not reported]	[Cell not reported]	
19	**Total with Donations** (Sum of Lines 17 and 18)	[Cell not reported]	[Cell not reported]	

Table 8A Cross-Table Considerations:

- The personnel and visits on Table 5 are routinely compared to the costs on Table 8A. See the crosswalk of comparable fields in Appendix B.
- Report the value of donated goods and services received on Table 8A. Report cash donations received on Table 9E.

Instructions for Table 9D: Patient Service Revenue

This table collects patient service revenue, including charges, collections, and adjustments attributable to the calendar year.

The Health Center Program Compliance Manual requires that **all** health centers have a fee schedule, based on locally prevailing rates and actual health center costs, and that they discount these fees (see discussion regarding sliding fee discounts) based on a patient's income and family/household size. Health centers are also required to make reasonable efforts to collect payment from patients and/or their third-party payers, consistent with Health Center Program Compliance Manual requirements.

There are no major changes to this table.

TABLE 9D: PATIENT SERVICE REVENUE – INSTRUCTIONS

This table reports charge, collection, and adjustment data for patient services provided within the health center's scope of federal project.

Revenue reported on Table 9D generally aligns with the classification of patients by type of medical insurance reported on Table 4. A crosswalk that shows this alignment is available in Appendix B.

ROWS: PAYER CATEGORIES AND FORM OF PAYMENT

Five major payer categories are listed: Medicaid, Medicare, Other Public, Private, and Self-Pay. All but Self-Pay have three sub-categories: non-managed care, capitated managed care, and fee-for-service managed care.

Only report charges, collections, and adjustments **as managed care** when all of the following criteria are met:

- There is a contract between the health center or a health center provider and an MCO, where the health center assumes some risk (often monetarily or tied to quality and/or cost).
- Managed care enrollees are assigned to the health center and/or a primary care provider (PCP) within the health center, where the health center is held responsible for the comprehensive care of those attributed patients under the specified service contract (e.g., medical, dental, and/or behavioral health).
- Monthly **enrollee** data (also sometimes called attribution lists or membership data) are provided by or are available from the MCO, such as from an online portal or from an account manager.

Payer Categories

Medicaid (Lines 1–3)

- Report all services billed to and paid for by Medicaid (Title XIX), including:
  - Medicaid managed care plans that may be operated by private insurers. For example, in states with a capitated Medicaid program, the health center may have a contract with a private plan like Blue Cross to administer the plan. The payer would be Medicaid, even though the actual payment may have come from Blue Cross.
  - EPSDT, which has various names in different states and is a part of Title XIX. The EPSDT program includes some children who are eligible for limited outpatient screening and treatment services only and are not included in the rest of the Medicaid program. Report their charges on Line 1.
  - CHIP, which has different names in different states, if paid through Medicaid.

- Medicaid expansion programs that provide funds for eligible individuals to purchase their own insurance, if it is possible to identify them. Otherwise report as Private.
- The portion of charges for dually eligible patients that are reclassified to Medicaid after being initially submitted to Medicare.
- The portion of the charge paid by Medicaid for Medicaid patients enrolled in a "share of cost" program.
- ADHC or Program of All-Inclusive Care for the Elderly (PACE) if administered by Medicaid. Treat as discussed in Appendix B.

Medicare (Lines 4–6)

- Report all services billed to and paid for by Medicare (Title XVIII), including:
  - Medicare managed care plans, including Medicare Advantage plans run by private insurers. For example, where the health center has a contract with a private plan like Blue Cross for Medicare Advantage, consider the payer to be Medicare, even though the actual payment may come from Blue Cross.
  - The portion of charges for patients covered through multiple insurances (e.g., Medicare and Medicaid, Medicare and Private) that are initially paid for by Medicare.
  - ADHC or PACE if administered by Medicare. Treat as discussed in Appendix B.

Other Public (Lines 7–9)

- Report all services billed to and paid for by state or local government programs, including:
  - CHIP **when paid for through private insurers**. (See Lines 1–3 if CHIP is paid through Medicaid.)
  - Family planning programs such as Title X programs, BCCEDPs (with various state names), and other dedicated state or local programs.

Note: Although these categorical grant programs are considered Other Public payers, patients are generally classified as Uninsured on Table 4 because the programs do NOT cover comprehensive primary care.

  - State-run insurance plans.
  - Municipal or county jails and state prisons.
  - Public schools and institutions that engage with the health center on a fee-for-service or other service-based contract basis.
- DO NOT include:
  - State or local indigent care programs. Report their charges, any associated self-pay collections, etc. on the Self-Pay line of Table 9D, Line 13 and program funds received on Table 9E, Line 6a, as described below.
  - Third-party coverage purchased through state or federal exchanges (which may be subsidized). Report as Private.
  - Patients covered through subsidies from a Medicaid expansion program. Report as Medicaid.

Private (Lines 10–12)

- Report all services billed to and paid for by private (commercial) insurance companies or by other third-party payers, including:
  - Insurance purchased for public employees or retirees, such as Tricare, Trigon, and the Federal Employees Health Benefits Program, as these are benefits belonging to the patient.
  - Workers' compensation, which is a form of liability coverage for employers.

- Insurance purchased through state exchanges, unless you can identify the patient as being enrolled through purchased subsidies from a Medicaid expansion program.
- Contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis, such as a Head Start program that pays for annual physical exams at a contracted rate or a private school, private jail, or large company that pays for a provision of medical care at a per-session or other negotiated rate.
- Supplemental insurance (plans that typically cover some amounts not paid or disallowed by Medicare).

- DO NOT report Medicaid, Medicare, or Other Public managed care plans administered by private insurers as Private.

Self-Pay (Line 13)

- Report all charges and related collections where the patient is responsible, including:
  - The full charge of services for uninsured patients with no insurance coverage.
  - Co-payments, deductibles, and charges to insured individuals for non-covered services that become the patient's personal responsibility.
  - Medicaid patients enrolled in a "share of cost" program in which they pay some portion of the fee as a co-payment or a deductible. In this case, reclassify the patient's share of the cost to Self-Pay, Line 13.
  - State or local indigent care programs that subsidize services rendered to the uninsured.
    - Report all charges for these services and collections from patients on the Self-Pay line (Line 13, Columns A and B).
    - Report all amounts not collected or due from the patients as sliding fee discounts or bad debt write-off, as appropriate, on Line 13, Columns E and F.
    - Report collections from the associated state and local indigent care programs on Table 9E, Line 6a, and specify the name of the program paying for the services.

Form of Payment

Non-Managed Care—Fee-for-Service

A payment model in which procedures and services are separately charged and paid for patients not assigned to the health center under a managed care contract. Third-party payers pay some or all of the bill, generally based on agreed-upon maximums or discounts.

Managed Care—Capitated

A payment model in which a health center contracts with an MCO for a list of services. The MCO pays the health center a capitation fee (a set amount, usually paid monthly, for each enrolled patient assigned to the health center) **regardless of whether any services were rendered during the month**. No further direct payment is provided if the services rendered are on the list of services covered by the capitation fee in the agreement between the health center and the MCO.

Managed Care—Fee-for-Service

A payment model in which a health center contracts with an MCO, is assigned patients for whom the health center is responsible for providing primary care services and is reimbursed on a fee-for-service (or encounter-rate) basis for covered services.

Managed Care—Combined Capitation and Fee-for-Service

A common payment model in which some of the services covered by the MCO are reimbursed with a capitation payment and the remainder of covered services are "carved out" and reimbursed on a fee-for-service basis. Carve-outs may include treatment of specific diseases (e.g., HIV) or specific services (e.g., prenatal care, labor/delivery). In this situation, the charges, collections, and adjustments are separately reported on the corresponding managed care lines—those that are for a defined set of services covered by the capitation and those that are reimbursed on a fee-for-service basis.

COLUMNS: CHARGES, PAYMENTS, AND ADJUSTMENTS RELATED TO SERVICES DELIVERED

Column A: Full Charges This Period

- Report total charges for patient services provided during the calendar year by each payer source. This will initially reflect the total full charges (per the health center's fee schedule) for patients whose services were billed to that payer category during the calendar year.
- Report charges based on the organization's fee schedule for services that are billed to and covered in whole or in part by a payer, or the patient, even if some or all of them are subsequently written off as contractual adjustments, sliding fee discounts, or bad debts. Always report full gross charges according to the health center fee schedule, NOT a contracted or negotiated rate.

Note: Under no circumstances should the actual amount paid by Medicaid or Medicare (such as those described as FQHC, G-code, or T-code rates) or the amount paid by any other payer be used as the actual charges. Charges must come from the health center's schedule of fees, typically based on CPT codes, or retail charge (for pharmacy).

- Report pharmaceuticals dispensed through a (340B) contract pharmacy at the pharmacy's UCR gross charge, even though they have a contracted rate with third-party payers.
- Include charges for ancillary services, such as laboratory and imaging.
- Include charges for eyeglasses, durable medical equipment, and other similar supply items.
- Include charges for dispensing or injecting pharmaceuticals donated to the health center or directly to a patient if they appear on bills and are collected from first and third parties.
- DO NOT report:
    - "contractual adjustments" as a charge. Instead, report the difference between gross charges and the amount reimbursed from third parties as an Adjustment in Column D.
    - charges that are generally not billable to or covered by traditional third-party payers. Some examples include WIC services, parking or job training, and transportation and similar enabling services (not generally included in Column A, except where the payer [e.g., Medicaid] accepts billing and pays for these services).

Reclassifying Charges

Services may have been paid for by more than one source. For example, a patient may have a portion of their charge paid by their primary insurance and may have the remainder paid by a secondary insurer or the patient or both. Management information systems should automatically reclassify charges rejected by a payer.

- In these instances, report the charge accepted by the primary payer along with any negotiated adjustment amount for their portion of the services to that payer line.

- Transfer the charges for the balance to the secondary payer; after the secondary payer claim settles, transfer the balance to a tertiary payer (if one exists) and, eventually, to the patient as a Self-Pay charge.
- Only report the amount charged to each payer, reclassifying any portion of the charge to secondary or tertiary payers (if they exist).
- If reclassifying cannot be done automatically, manually transfer the amount rejected from the initial payer to the next payer.
- DO NOT reclassify charges by using an adjustment and rebilling to another payer category; this will result in an overstatement of total gross charges by reporting the charges twice.

Column B: Amount Collected This Period

- Report in Column B the gross receipts for the calendar year, including receipts for services that may have been rendered in a prior calendar year.
- Report FQHC reconciliations, managed care pool distributions, pay-for-performance (P4P) payments, quality bonuses, court settlements, and other payments in Column B **and** in Columns C1, C2, C3, and/or C4.
- When a contract pharmacy is dispensing 340B drugs on behalf of the health center, report the total cash received by the pharmacy separately for patients and third-party payers.
- Report the managed care capitation payments (monthly payments) received during the calendar year as a collection, NOT as a charge, on the capitation line.

Note: Report charges and collections for deductibles and co-payments that are charged to, paid by, and/or due from patients as Self-Pay on Line 13.

Columns C1–C4: Retroactive Settlements, Receipts, or Paybacks

- Report in Columns C1–C4 retroactive settlements, receipts, and paybacks, **in addition to including them in Column B**. The most common are Medicaid, Medicare, and CHIP FQHC cost report settlements and wraparound payments. Cost report settlements are lump-sum retroactive payments or recoupments based on the filing of a cost report. Wraparound payments are made periodically and represent the difference between amounts reimbursed and amounts due based upon the approved FQHC visit rates.
- Include managed care pool distributions, P4P incentive payments, quality bonuses, and paybacks to FQHC payers or HMOs.
- Report retroactive payments received from third parties from a current or prior calendar year, as appropriate, in Column B, subtract from Column D, and also report in Columns C1–C3.
- DO NOT report accruing anticipated receipts in Columns C1–C4. Only report retroactive settlements, receipts, or paybacks on a cash basis.
- DO NOT report wraparound payments if the State pays the FQHC rate upon billing. States that pay the FQHC rate rather than a market rate will typically not make wraparound reconciliation payments.

Column C1: Collection of Reconciliation/Wraparound, Current Year

- Report FQHC cash receipts from settlements and wraparound payments from Medicare, Medicaid, or Other Public payers that are for **services provided during the current calendar year.** Include the current-year component, if any, of multi-year settlements here.

Column C2: Collection of Reconciliation/Wraparound, Previous Years

- Report FQHC cash receipts from reconciliations and wraparound payments from Medicare, Medicaid, or Other Public payers that are for **services provided during previous calendar years**. Include the prior-year component of multiyear settlements here.

A supplemental wraparound payment may be made for each visit, including managed care visits, to adjust total payment to equal FQHC cost-based rates.

Apportion settlement data reported in Columns C1 and C2 between the fee-for-service lines and the managed care lines when both payment reimbursement methods are used. You may use the percentage distribution of visits, charges, or net charges as the basis for the allocation if exact amounts are unknown.

Note: Columns C1 and C2 are not reported and are grayed out on the Private payer and Self-Pay lines.

Column C3: Collection of Other Payments Including Pay for Performance, Quality Bonuses, Risk Pools, and Incentives

- Report other cash payments, including managed care risk pool redistribution, incentives including P4P incentives, and quality bonuses from any payer.
- Include payment for patients enrolled in the CMS primary care demonstration projects, regardless of whether there is a visit involved.
- Report settlements that result from a court decision that requires a payer to make a settlement to the health center, including a multiyear settlement. These payments may apply to either a managed care or non-managed care payer.
- DO NOT report eligible provider payments from CMS for implementing EHRs (referred to as Promoting Interoperability Programs payments). Report these payments on Table 9E, Line 3a.

Note: Column C3 is not reported and is grayed out on the Self-Pay line.

Column C4: Penalty/Payback

- Report, as a positive number, refund payments made by the health center to payers because of overpayments. Only report amounts paid back during the calendar year.
- Report "penalty" payments made to payers due to the health center's failure to meet utilization or other performance goals.
- If a check was written for the payback, report the payback amount in Column C4, subtract this amount from Column B, and add it to Column D as an adjustment. Alternatively, if the payback amount is deducted from a remittance, report it in Column C4, but DO NOT adjust Columns B or D.

Note: Column C4 is not reported and is grayed out on the Self-Pay line.

Column D: Adjustments

Virtually all insurance companies have a maximum amount they pay for a given service and the health center agrees to write off the difference between what they charge and that contracted amount. These are reported as contractual adjustments.

- Report in Column D adjustments granted as part of an agreement with a third-party payer.

- Report adjustments as a positive number, unless as you reduce the initial adjustment by the amount of retroactive settlements and receipts (reported in Columns C1, C2, and C3), current- and prior-year FQHC reconciliations, managed care pool distributions, quality or P4P awards, and other payments the result is a negative number. A negative adjustment means more was received for the service than charged.

Note: Adjustments that have the normal effect of reducing the charge are reported without brackets or a minus sign in Column D, and those that have the effect of increasing charges are reported as a negative number. Adjustments will not normally exceed charges.

- Capitated managed care plans (Lines 2a, 5a, 8a, and 11a only) typically pay on a per-member, per-month basis and make payments in the current month of enrollment, which means these plans are typically the only plans that DO NOT carry significant receivables. In these instances, report the difference between the charges for the capitated services provided and the capitation earned during the calendar year (Column A minus Column B) as the adjustment (Column D), unless there are early or late capitation payments.
- No adjustments can be entered on Line 13 (Self-Pay), because patient adjustments are recognized as either sliding fee discounts (Line 13, Column E) or as self-pay bad debt (Line 13, Column F).
- If your organization records capitation receipts in the general ledger, this will require that the charges for capitation services be eliminated from the PMS with an adjustment, as no payment is expected to be recorded in the PMS. DO NOT report these in Column D. Only report adjustments in Column D that are the difference between the charges for capitated services and the capitations earned. If the capitations earned were all received during the calendar year, the adjustment will equal the difference between Column A and Column B. If not all of the capitations earned were received during the calendar year, Column A less Column B less Column D will equal the capitation amount due to the health center.
- DO NOT report amounts for which another third party or a patient is billed (e.g., amounts due from patients or "Medigap" payers for co-payments) as adjustments. Transfer these charges from the primary payer to the secondary and subsequent payers.
- Reconciliations are lump-sum retroactive adjustments based on the filing of a settlement report. Report charges based on the organization's fee schedule for services that are billed to and covered in whole or in part by a payer or the patient, even if some or all of them are subsequently written off as contractual adjustments.

Note: Column D is not reported and is grayed out on the Self-Pay line.

Column E: Sliding Fee Discounts

The health center's sliding fee discount policies and procedures determine the discounts, if any, to apply to charges owed by patients.

- Report the amount of sliding fee discounts applied to patient charges based on the patient's ability to pay using patient's income and family/household size.
- Include sliding discounts applied to co-payments and deductibles, as applicable.
- Report prompt pay discounts provided under a hardship fee waiver program as sliding fee discounts.
- DO NOT report:
  - automatic discounting of charges for specific categories of patients (e.g., students, patients experiencing homelessness, or agricultural workers) as a sliding fee discount.
  - bad debt write-off or forgiveness as a sliding fee discount.
  - other types of discounts that DO NOT meet the criteria as a sliding fee discount.

Note: Column E is grayed out on all third-party payer lines and only available on the Self-Pay line.

Note: When a sliding fee discount is used to write off part of a charge originally made to a third party, such as Medicare or a private insurance company's co-payment or deductible, first transfer or reclassify the charge to self-pay. To transfer or reclassify, first reduce the third-party charge by the amount due from the patient and then increase the self-pay charges by the same amount.

Column F: Bad Debt Write-Off

Bad debt write-off may occur due to the health center's inability to locate patients, a patient's refusal to pay, a patient's inability to pay for amounts not subject to a sliding fee discount, or a patient's inability to pay even after the sliding fee discount is granted.

- Report amounts billed to and defaulted on by any patient. Report bad debts only from patients as self-pay bad debts.
- Report either the amount directly written off from patient accounts during the calendar year or the amount of change in the allowance account attributable to self-pay as of the end of the calendar year.
- DO NOT report the bad debt associated with third parties, which may include charges that were not billed within the time permitted by the payer, charges for services rendered to insured patients by providers who were not credentialed by that payer, charges due from payers who are bankrupt, and similar bad debts. These are not currently reported on the UDS.

Note: Column F is available only on the Self-Pay line and is grayed out on all third-party payer lines.

Total Patient Service Revenue (Line 14)

Sum of Lines 3 + 6 + 9 + 12 + 13.

FAQ FOR TABLE 9D

1. **How should charges and collections for patients enrolled in an indigent care program be handled?**

   Report indigent care program charges as Self-Pay, Line 13, in Column A.

   Report the payments, whether made on a per-visit basis or as a lump sum for services rendered, on Line 6a of Table 9E. See cross-table reporting guidance for indigent programs for specific instructions.

   DO NOT report on this table payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured.

   DO NOT report anything as an indigent care program without first reviewing this with the UDS Support Center or your UDS Reviewer.

2. **Should the charges less collections less adjustments equal zero?**

   No, normally this is NOT equal to zero. Charges (Column A) minus collections (Column B) minus adjustments (Columns D, E, and F) equals the change in accounts receivable or the amount by which what is owed to the health center increases or decreases during the calendar year. Straight capitation plans (Lines 2a, 5a, 8a, and 11a) may show no change in accounts receivable assuming all capitations earned were received during the calendar year. Combined capitation and fee-for-service managed care plans may occasionally show a change in accounts receivable on the capitation line due to pending charges, which would be for services not covered by the capitation that have yet to be transferred to the fee-for-service managed care line.

3. **If we have not received any reconciliation payments for the calendar year, what do we report in Column C1 (current-year reconciliations)?**

   Only those cost report settlements and wraparound reconciliations attributable to the report calendar year are reported in Column C1, so report zero in Column C1.

4. **We often use our sliding fee discount program to write off the co-payment portion of the Medicare charge for our certified low-income patients. The sliding fee discount column (Column E) is grayed out for Medicare. How do we record this write-off?**

   It is grayed out for Medicare because the write-off is applied to the patient, not Medicare. To do this, reclassify or transfer the amount of the co-payment from the charge column of the Medicare line (Lines 4–6, as appropriate) to the Self-Pay line (Line 13). It can then be written off as a sliding fee discount on Line 13. Use the same process for any other third-party payer co-payment or deductible write-off for patients who received a sliding fee discount.

5. **Our system does not automatically reclassify amounts due from other carriers or from the patient. Must we, for example, reclassify Medicare charges that become co-payments or Medicaid charges?**

   Yes. Regardless of whether it is done automatically by your PMS/health IT/EHR or manually, reflect this reclassification of charges that end up being the responsibility of a party other than the initial party. As a rule, your system will make this adjustment in some way, but you may need to work with your vendor to get a report on the amounts transferred or consult with the UDS Support Center or UDS Reviewer about how to do this.

6. **How do we report the charges and collections for pharmaceuticals dispensed at our contract pharmacies?**

   We discuss contract pharmacy reporting at length in Appendix B. In general, report the full charge in Column A by payer. Report the amount received from the payer on the line corresponding to whom the payment was received from in Column B. Report the amount that is written off for an insurance company in Column D. Report any sliding discount amount written off for a patient as a sliding fee discount in Column E. Similar rules apply if drugs are billable to Medicaid and Medicare.

7. **What is the timing for revenue reporting (charges, collections, adjustments) on Table 9D?**

   Charges are to be reported based on the date of service and should be limited to dates of service that occurred during 2024. Collections and adjustments are reported based on posting date (which is typically the date the payment is received/posted and the health center received an explanation of benefits or similar document outlining reimbursement details) and are to be limited to those transactions posted during 2024.

8. **How should we report the charges associated with "G-codes"?**

   G-codes specify a *reimbursement rate* associated with a service or package of services that your health center has described to Medicare. They are NOT reported as charges or with fee schedule charges. (Similar amounts may be paid to you by other third-party payers as well.) For UDS, report these in:

   - Column A: The sum of actual fee schedule/CPT-related charges for visits
   - Column B: What your health center received for payment
   - Column D: The discounted amount disallowed between charges and the amount received

   Remember to reduce the charges by the Medicare co-payment (20% of the allowable charge) and to reclassify them to the secondary payer or the patient, as appropriate. See discussion of reclassifying co-payments.

Note: If both the actual charge and the G-code charge are routinely applied to the visit by your system, you must remove the G-code charges by running a report to get the total for G-code charges for the year and then subtracting this number from the total charges (actual plus G-code). Report the difference in Column A. Reduce Column D by the G-code amount if it was adjusted using a similar process.

TABLE 9D: PATIENT SERVICE REVENUE

Calendar Year: January 1, 2024, through December 31, 2024

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write-Off (f)**
1	Medicaid Non-Managed Care								[not reported]	[not reported]
2a	Medicaid Managed Care (capitated)								[not reported]	[not reported]
2b	Medicaid Managed Care (fee-for-service)								[not reported]	[not reported]
3	**Total Medicaid** (Sum of Lines 1 + 2a + 2b)								[not reported]	[not reported]
4	Medicare Non-Managed Care								[not reported]	[not reported]
5a	Medicare Managed Care (capitated)								[not reported]	[not reported]
5b	Medicare Managed Care (fee-for-service)								[not reported]	[not reported]
6	**Total Medicare** (Sum of Lines 4 + 5a + 5b)								[not reported]	[not reported]
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care								[not reported]	[not reported]
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)								[not reported]	[not reported]
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)								[not reported]	[not reported]
9	**Total Other Public** (Sum of Lines 7 + 8a + 8b)								[not reported]	[not reported]

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	**Payer Category**	**Full Charges This Period (a)**	**Amount Collected This Period (b)**	**Collection of Reconciliation/ Wraparound Current Year (c1)**	**Collection of Reconciliation/ Wraparound Previous Years (c2)**	**Collection of Other Payments: P4P, Risk Pools, etc. (c3)**	**Penalty/ Payback (c4)**	**Adjustments (d)**	**Sliding Fee Discounts (e)**	**Bad Debt Write-Off (f)**
10	Private Non-Managed Care			[not reported]	[not reported]				[not reported]	[not reported]
11a	Private Managed Care (capitated)			[not reported]	[not reported]				[not reported]	[not reported]
11b	Private Managed Care (fee-for-service)			[not reported]	[not reported]				[not reported]	[not reported]
12	**Total Private** (Sum of Lines 10 + 11a + 11b)			[not reported]	[not reported]				[not reported]	[not reported]
13	**Self-Pay**			[not reported]	[not reported]	[not reported]	[not reported]	[not reported]		
14	**TOTAL** (Sum of Lines 3 + 6 + 9 + 12 + 13)									

Table 9D Cross-Table Considerations:

- Charges and collections by payer on Table 9D are related to the classification of patients by medical insurance on Table 4. See the crosswalk of comparable fields in Appendix B. For example, dividing Medicaid revenue on Table 9D, Line 3, Column B by Total Medicaid Patients on Table 4, Line 8 equals the average collection per Medicaid patient.
- Other Public charges and collections on Table 9D are generally not directly comparable to Table 4 Other Public. Categorical grants such as Title X and BCCEDP are NOT insurance and the patients are usually classified as Uninsured on Table 4, but their associated charges and collections are shown as Other Public on Table 9D.
- Managed care revenue on Table 9D relates to member months on Table 4. Dividing managed care capitation revenue by member months equals average capitation per member per month (PMPM). For example, dividing Medicaid capitation revenue (Table 9D, Line 2a, Column B − (c1 + c2 + c3 − c4)) by Table 4, Line 13a, Column A equals Medicaid PMPM.
- Billable visits reported on Table 5 should relate to patient charges reported on Table 9D.

Instructions for Table 9E: Other Revenue

Table 9E reports revenue-related non–patient service receipts, including grants, contracts, and other funds received in the calendar year from sources supporting the scope of project. This table includes all revenue received that are not directly tied to the delivery of a specific patient service.

There are no major changes to this table.

TABLE 9E: OTHER REVENUE – INSTRUCTIONS

This table provides information about the health center's receipt of funds used to support in-scope activities not reported on Table 9D.

- Report all non–patient service-related funds **received** during the calendar year that supported the federally approved scope of project.
- Use the **"last party rule"** to classify the receipts. The "last party rule," for UDS reporting purposes, means that grant, contract, and other funds should always be reported based on the entity from which the health center received them, regardless of the source from which they originated.
- DO NOT report any receipts on both Tables 9D and 9E, as this will duplicate the cash revenue received.

Note: Tables 9D and 9E receipts are summed to equal total cash revenue received during the calendar year.

HRSA'S BPHC GRANTS

Health Center Program Grants, Lines 1a Through 1e

- Report **drawdowns** received during the calendar year for the Health Center Program (section 330) grant, including:
  - Amounts consistent with the Payment Management Services (PMS)-272 federal cash transaction report. Report grant drawdowns as follows:
    - MHC on Line 1a
    - CHC on Line 1b
    - HCH on Line 1c
    - PHPC on Line 1e
  - Supplemental funding (with the exception of COVID-19) from HRSA is provided as part of the 330 grant. Report these grant funds on the appropriate 330 grant Lines 1a–1e, as specified in the health center Notice of Award.
  - Direct funding, including NAP or expansion funds, is reported only on these lines.
  - Include amounts that the health center received and passed through to another Health Center Program awardee.
- DO NOT reduce the drawdown by the amount the health center passed through to another health center, including sub-awardees or sub-recipients.
- If you are a look-alike or BHW primary care clinic, DO NOT report grant receipts from HRSA's BPHC Health Center Program on these lines. The fields are grayed out in the EHBs.

Total Health Center Program (Line 1g)

Sum of Lines 1a through 1e.

Capital Development Grants (Line 1k)

- Report the amount of HRSA's BPHC Capital Development Grant dollars drawn down.
- Include funds from the Health Center Program facility program and funds from the HRSA-administered school-based service site capital grant program.
- Report Capital Assistance for Hurricane Response and Recovery Efforts (CARE), Capital Assistance for Disaster Response and Recovery Efforts (CADRE), and other funds awarded by HRSA to assist in the reconstruction and repair of facilities destroyed or damaged by natural disasters.

COVID-19 Supplemental Funding

Lines 1l through 1p2

- Report **drawdowns** received during the calendar year for COVID-19 supplemental funding, consistent with the PMS-272 federal cash transaction report. Report grant drawdowns as follows:
  - Coronavirus Preparedness and Response Supplemental Appropriations Act (activity code H8C) (Line 1l)
  - Coronavirus Aid, Relief, and Economic Security (CARES) Act (activity code H8D) (Line 1m)
  - Expanding Capacity for Coronavirus Testing (activity code H8E and ECT) (Line 1n)
  - American Rescue Plan (ARP), including ARP capital improvement grants (activity code H8F, L2C, and C8E) (Line 1o)
  - Expanding COVID-19 Vaccination (ECV) (activity code H8G) (Line 1p)
  - Other COVID-19-related funding drawn down from HRSA's BPHC grants (Line 1p2), including Bridge to Access (activity code H8L). Use the "specify" field to detail the names and amounts of other COVID-19-related funding from HRSA.

Total COVID-19 Supplemental (Line 1q)

Sum of Lines 1l through 1p2.

Total HRSA's BPHC Grants (Line 1)

Sum of Lines 1g + 1k + 1q.

OTHER FEDERAL GRANTS

Ryan White Part C—HIV Early Intervention Grants (Line 2)

- Report drawdowns received during the calendar year for Ryan White Part C cash receipts.
- Guidance for reporting funds from other Ryan White titles is provided in the FAQ for Table 9E.

Other Federal Grants (Line 3)

Federal grants include only those funds received directly by the health center from the U.S. Treasury for which there is a Notice of Federal Award. Examples of common "other federal" grants reported are from the Bureau of Health Workforce (BHW), the Office of Minority Health (OMH), the Indian Health Service (IHS), the Department of Housing and Urban Development (HUD), Federal Communications Commission, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

- Report drawdowns received during the calendar year for any other federal grants that are within the scope of project. Use the "specify" field to detail the names and amounts of other federal grants.
- Include IHS funds (not including P.L. 93-638 Compact funds) if your health center is dually funded as an IHS/HRSA-funded health center. Report PL 93-638 Compact funds on Line 6a, Indigent Care.
- Include ARP funds drawn down from other HRSA bureaus (not HRSA's BPHC or Ryan White Part C) or from other federal agencies.

Medicare and Medicaid EHR Incentive Grants for Eligible Providers (Line 3a)

CMS provides incentives to eligible providers (as defined by CMS) for the adoption, implementation, upgrading, and improvement of interoperability of certified EHRs.

- Report grants funded through CMS from the Medicare and Medicaid EHR Incentive Program (now known as "Promoting Interoperability Programs").
- In rare cases, these payments go directly to the health center's providers, but they are usually paid to the providers' designee (generally, the health center). It is presumed that if the payment goes to the providers these funds will be turned over to the health center. Report them on this line even though the payment may come from the provider and not directly from CMS. This is an exception to the "last party" rule. In the event the provider retains some or all of these incentives as part of their compensation, report the total amount on this line and the amount retained by the provider on Table 8A, Line 1, as personnel compensation.

Provider Relief Fund (Line 3b)

- Report funds from the CARES Act Provider Relief Fund through HHS. These funds provide relief to eligible providers for health care–related expenses or lost revenues that are attributable to the novel coronavirus.

Total Other Federal Grants (Line 5)

Sum of Lines 2 + 3 + 3a + 3b.

NON-FEDERAL GRANTS OR CONTRACTS

State Government Grants and Contracts (Line 6)

- Report cash received during the calendar year for any state government grants or contracts that are within the health center scope of project and for which the health center receives the funds with no specific tie to services provided. Use the "specify" field to detail the names and amounts of state government grants and contracts.
- Most include line-item budgets that support specific personnel positions or other costs.

- DO NOT report receipts from state governments that pay based on the amount of health care services provided or on a negotiated fee-for-service or fee-per-visit. Report charges, collections, and adjustments on Table 9D on the Other Public revenue lines.

State/Local Indigent Care Programs (Line 6a)

- Report the amount of funds received from state/local indigent care programs that are earmarked to subsidize services rendered to patients who are uninsured. Use the "specify" field to detail the names and amounts of state/local indigent care programs.
- Include amounts allocated to the health center by tribes from their IHS PL 93-638 Compact funds.
- DO NOT include revenue received under a contract with a tribal government for services provided to its members. Report as Other Public with charges, collections, and adjustments on Table 9D.
- Further guidance is available in Appendix B.

Local Government Grants and Contracts (Line 7)

- Report cash received during the calendar year for any local government grants or contracts that are within the scope of project and for which there is no specific tie to patient services provided. Use the "specify" field to detail the names and amounts of local government grants and contracts.
- Most include line-item budgets that support specific personnel positions or other costs.
- DO NOT include revenue received from local governments that pay based on amount of health care services provided or on a negotiated fee-for-service or fee-per-visit basis. Report charges, collections, and adjustments on Table 9D on the Other Public revenue lines.
- DO NOT include funds from local indigent care programs here. Report these on Line 6a.

Foundation/Private Grants and Contracts (Line 8)

- Report the amount received from foundations or private organizations during the calendar year that covers costs included within the scope of project. Use the "specify" field to detail the names and amounts of foundation/private grants and contracts.
- Include funds (including subaward funds) received directly from a primary care association (PCA), another health center, or another community service provider on this line, even when funds originate elsewhere.

Total Non-Federal Grants and Contracts (Line 9)

Sum of Lines 6 + 6a + 7 + 8.

Other Revenue (Line 10)

- Report other revenue receipts included in the federally approved scope of project that are unrelated to charge-based services or to grants and contracts described above. Use the "specify" field to detail the names and amounts of other revenue.
- Include fundraising, interest revenue, rent from tenants, patient health records fees, individual monetary donations, receipts from vending machines, retail pharmacy sales to the public (i.e., non–health center patients), etc.
- Include receipts related to the gain on the sale of an asset.

- **DO NOT** report:
  - the value of in-kind or other non-monetary donations made to the health center. Report these **only** on Table 8A, Line 18.
  - the proceeds of any loan received for operations, a mortgage, or other purposes.
  - the value of loans forgiven by the lender.
  - insurance proceeds related to a loss, unless the loss was recognized as an expense rather than a reduction in the value of an asset.
  - the receipt or recognition of in-kind "community benefit" from a third party here or anywhere else on the UDS unless it is received as a cash donation.
  - **under any circumstances,** payments or net payments from a pharmacy contracted to dispense 340B pharmaceuticals on this line (or anywhere on Table 9E). Report all revenue from pharmacy services provided to health center patients on Table 9D and record all expenses on Table 8A.

Total Other Revenue (Line 11)

Sum of Lines 1 + 5 + 9 + 10.

FAQ FOR TABLE 9E

1. **We received maternal and child health services funds from the state that originated from the federal government. On which line do we report these funds?**

   Use the "last party rule" to report on this table. In this instance, report these funds as state grants on Line 6, since the funds were awarded to the health center by the state for maternal and child health services, even though these may include a mixture of federal funds (such as Title V) and state funds.

2. **We receive various Ryan White–related funds. How do we report these?**

   This depends on which entity you received Ryan White funds from. Use the following to guide your reporting:

   - Report Ryan White Part A, Impacted Area grants, from county or city governments on Line 7. If they are first sent to a third party, report the funds on Line 8. Report on Line 3 when the reporting entity is a county or city government, and the funds were received directly from the Ryan White Part A federal program.
   - Report Part B grants from the state on Line 6, unless they are first sent to a county or city government (in which case, report on Line 7) or to a third party (in which case, report the funds on Line 8).
   - Report drawdowns received during the calendar year for Ryan White Part C on Line 2.
   - Report Part D funds from the HIV/AIDS Bureau on Line 3.
   - Report Part F funds, Special Projects of National Significance grants, received from the HIV/AIDS Bureau on Line 3.

3. Are there any important issues to keep in mind for this table?

This table collects information on cash receipts for the calendar year that supported activities described in the scope of project covered by any of the Health Center Program awards, the look-alike designation, or the BHW primary care clinics program.

In the case of a grant:

- Report the cash amount received during the calendar year.
- DO NOT report the award amount (unless the full award was paid/drawn down during the year).

4. How should we report indigent care funds?

- Report payments received from state or local indigent care programs subsidizing services rendered to patients who are uninsured (including patients covered by a tribe's 638 funds) on Line 6a of Table 9E, whether the actual payment to the health center is made on a per-visit basis or as a lump sum for services rendered.
- Report patients who received care during the year covered by these programs as Uninsured on Table 4.
- Report all charges, self-pay patient collections, sliding fee discounts, and bad debt write-offs on the Self-Pay line (Line 13) on Table 9D.
- Report amounts collected from the patients covered by indigent programs on Table 9D, Line 13, Column B. However, DO NOT report funds reported on Line 6a of Table 9E on Table 9D as collections, sliding discounts, or bad debt.

TABLE 9E: OTHER REVENUES

Calendar Year: January 1, 2024, through December 31, 2024

Line	Source	Amount (a)
	HRSA's BPHC Grants (Enter Amount Drawn Down—Consistent with PMS 272)	
1a	Migrant Health Center	
1b	Community Health Center	
1c	Health Care for the Homeless	
1e	Public Housing Primary Care	
1g	**Total Health Center** (Sum of Lines 1a through 1e)	
1k	**Capital Development Grants**, including School-Based Service Site Capital Grants	
1l	Coronavirus Preparedness and Response Supplemental Appropriations Act (H8C)	
1m	Coronavirus Aid, Relief, and Economic Security Act (CARES) (H8D)	
1n	Expanding Capacity for Coronavirus Testing (ECT) (H8E and LAL ECT)	
1o	American Rescue Plan (ARP) (H8F, L2C, C8E)	
1p	Expanding COVID-19 Vaccination (ECV) (H8G)	
1p2	Other COVID-19-Related Funding from HRSA's BPHC (specify _____)	
1q	**Total COVID-19 Supplemental** (Sum of Lines 1l through 1p2)	
1	**Total HRSA's BPHC Grants** (Sum of Lines 1g + 1k + 1q)	
	Other Federal Grants	
2	Ryan White Part C HIV Early Intervention	
3	Other Federal Grants (specify _____)	
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	
3b	Provider Relief Fund (specify _____)	
5	**Total Other Federal Grants** (Sum of Lines 2 through 3b)	
	Non-Federal Grants or Contracts	
6	State Government Grants and Contracts (specify _____)	
6a	State/Local Indigent Care Programs (specify _____)	
7	Local Government Grants and Contracts (specify _____)	
8	Foundation/Private Grants and Contracts (specify _____)	
9	**Total Non-Federal Grants and Contracts** (Sum of Lines 6 + 6a + 7 + 8)	
10	Other Revenue (non–patient service revenue not reported elsewhere) (specify _____)	
11	**Total Revenue** (Sum of Lines 1 + 5 + 9 + 10)	

Table 9E Cross-Table Considerations:

- Pharmacy: Only retail, public pharmacy revenue for non–health center patients is reported on Table 9E, Line 10, and the related cost is reported on Table 8A, Line 12. Follow the guidance for other pharmacy reporting situations as described in Appendix B.
- The revenue received from indigent care programs that subsidize services rendered to patients who are uninsured are reported on Table 9E, while the charges for these services are reported on Table 9D. Follow the detailed reporting requirements included in Appendix B to address the cross-table reporting.

Appendix A: Listing of Personnel

All line numbers in the following table refer to Table 5. NOT all services delivered by a "provider" count as visits. DO NOT count encounters with "non-providers" as countable visits. Use the Provider definitions to classify personnel as a "provider" or "non-provider."

Personnel by Major Service Category	Provider	Non-Provider
Physicians		
Family practitioners (Line 1)	X	
General practitioners (Line 2)	X	
Internists (Line 3)	X	
Obstetricians/Gynecologists (Line 4)	X	
Pediatricians (Line 5)	X	
Licensed medical residents—line determined by specialty	X	
Other Specialist Physicians (Line 7)		
Allergists	X	
Cardiologists	X	
Dermatologists	X	
Endocrinologists	X	
Orthopedists	X	
Surgeons	X	
Urologists	X	
Other specialists and sub-specialists	X	
Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives		
Nurse practitioners (Line 9a)	X	
Physician assistants (Line 9b)	X	
Certified nurse midwives (Line 10)	X	
Nurses (Line 11)		
Clinical nurse specialists	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses (RNs)	X	
Licensed practical nurses/Licensed vocational nurses		X
Nurse emergency medical services (EMS)/Nurse emergency medical technicians (EMT)	X	
Other Medical Personnel (Line 12)		
Nurse aides/assistants (certified and uncertified)		X
Clinic aides/medical assistants (certified and uncertified medical technologists)		X
Unlicensed interns and residents		X
EMS/EMT personnel (not credentialed as a nurse)		X
Laboratory Personnel (Line 13)		
Pathologists		X
Medical technologists		X
Laboratory technicians		X
Laboratory assistants		X
Phlebotomists		X
X-Ray Personnel (Line 14)		
Radiologists		X
X-ray technologists		X
X-ray technicians		X
Radiology assistants		X
Ultrasound technicians		X

Personnel by Major Service Category	Provider	Non-Provider
Dentists (Line 16)		
General practitioners	X	
Oral surgeons	X	
Orthodontists	X	
Periodontists	X	
Endodontists	X	
Dental Hygienists (Line 17)		
Dental hygienists	X	
Dental Therapists (Line 17a)		
Dental therapists	X	
Other Dental Personnel (Line 18)		
Dental assistants, advanced practice dental assistants		X
Dental technicians		X
Dental aides		X
Dental students (including hygienist students)		X
Mental Health (Line 20) **and Substance Use** (Line 21)		
Psychiatrists (Line 20a)	X	
Psychologists (Line 20a1)	X	
Social workers—clinical (Line 20a2 or 21)	X	
Social workers—psychiatric (Line 20b or 21)	X	
Family therapists (Line 20b or 21)	X	
Psychiatric nurse practitioners (Line 20b)	X	
Nurses—psychiatric and mental health (Line 20b)	X	
Unlicensed mental health providers, including trainees (interns or residents) and "certified" personnel (Line 20c)	X	
Unlicensed substance use disorder providers, including trainees (interns or residents) and "certified" personnel (Line 21)	X	
Alcohol and drug abuse counselors (Line 21)	X	
RN counselors (Line 20b or 21)	X	
Peer recovery coaches and workers (Line 21)	X	
Other Professional Health Services Personnel (Line 22)		
Audiologists	X	
Acupuncturists	X	
Chiropractors	X	
Community or behavioral health aides/practitioners	X	
Herbalists	X	
Massage therapists	X	
Naturopaths	X	
Registered dietitians, including nutritionists/dietitians	X	
Occupational therapists	X	
Orthotists	X	
Podiatrists	X	
Physical therapists	X	
Respiratory therapists	X	
Speech therapists/pathologists	X	
Traditional healers	X	
Occupational therapy assistants		X
Physical therapy assistants		X
Vision Services Personnel		
Ophthalmologists (Line 22a)	X	
Optometrists (Line 22b)	X	

Personnel by Major Service Category	Provider	Non-Provider
Ophthalmologist/optometric assistants (Line 22c)		X
Ophthalmologist/optometric aides (Line 22c)		X
Ophthalmologist/optometric technicians (Line 22c)		X
Personnel by Major Service Category	**Provider**	**Non-Provider**
Pharmacy Personnel		
Pharmacists (Line 23a)		X
Clinical pharmacists (Line 23b)		X
Pharmacy technicians (Line 23c)		X
Pharmacist assistants (Line 23d)		X
Pharmacy clerks (Line 23d)		X
Case Managers (Line 24)		
Case managers	X	
Care/referral coordinators	X	
Patient advocates	X	
Social workers	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses	X	
Licensed practical nurses/licensed vocational nurses	X	
Health Education Specialists (Line 25)		
Family planning counselors	X	
Patient health educators/specialists	X	
Social workers	X	
Public health nurses	X	
Home health nurses	X	
Visiting nurses	X	
Registered nurses	X	
Licensed practical nurses/licensed vocational nurses	X	
Community and group educators/specialists		X
Outreach Workers (Line 26)		
Outreach workers		X
Transportation Workers (Line 27)		
Patient transportation coordinators		X
Drivers, including mobile van drivers		X
Eligibility Assistance Workers (Line 27a)		
Benefits assistance workers		X
Pharmacy assistance program (PAP) eligibility workers		X
Eligibility workers		X
Patient navigators		X
Patient advocates		X
Registration clerks		X
Certified assisters		X
Interpretation Personnel (Line 27b)		
Interpreters		X
Translators		X
Community Health Workers (Line 27c)		
Community health workers		X
Community health advisors or representatives		X
Lay health advocates		X
Peer health promoters/educators		X
Promotoras		X

Personnel by Major Service Category	Provider	Non-Provider
Personnel Performing Other Enabling Services Activities (Line 28)		
Other enabling services personnel		X
Other Programs and Related Services Personnel (Line 29a)		
WIC workers		X
Head Start workers		X
Housing assistance workers		X
Child care workers		X
Food bank/meal delivery workers		X
Employment/educational counselors		X
Exercise trainers/fitness center personnel		X
Adult day health care, frail elderly support personnel		X
Quality Improvement Personnel (QI) (Line 29b)		
QI nurses		X
QI technicians		X
QI data specialists		X
Statisticians, analysts		X
Quality assurance/quality improvement and health IT/EHR design and operation personnel		X
Management and Support Personnel (Line 30a)		
Project directors		X
Chief executive officers/executive directors		X
Chief financial officers/fiscal officers		X
Chief information officers		X
Chief medical officers		X
Secretaries/administrative assistants		X
Administrators		X
Directors of planning and evaluation		X
Personnel directors		X
Receptionists		X
Directors of marketing		X
Marketing representatives		X
Enrollment/service representatives		X
Fiscal and Billing Personnel (Line 30b)		
Finance directors		X
Accountants		X
Bookkeepers		X
Billing clerks		X
Cashiers		X
Data entry clerks		X
IT Personnel (Line 30c)		
Directors of data processing		X
Programmers		X
IT help desk technicians		X
Data entry clerks		X
Facility Personnel (Line 31)		
Janitors/custodians		X
Security guards		X
Groundskeepers		X
Equipment maintenance personnel		X
Housekeeping personnel		X

Personnel by Major Service Category	Provider	Non-Provider
Patient Services Support Personnel (Line 32)		
Medical and dental team clerks		X
Medical and dental team secretaries		X
Medical and dental appointment clerks		X
Medical and dental patient health records clerks		X
Patient health records supervisors		X
Patient health records technicians		X
Patient health records clerks		X
Patient health records transcriptionists		X
Registration clerks		X
Appointments clerks		X

Appendix B: Special Multi-Table Situations

Several conditions require special consideration in the UDS because they affect multiple tables that must then be reconciled. This appendix presents some situations along with instructions on how to deal with them, including:

- Contracted care (specialty, dental, mental health, etc.) that is paid for by the reporting health center
- Services provided by a volunteer provider
- Interns and residents
- WIC
- In-house pharmacy or dispensary services for health center patients
- In-house pharmacy for community (i.e., for non-patients)
- Contract pharmacies
- Donated drugs
- Clinical dispensing of drugs
- ADHC and PACE
- Medi-Medi crossovers
- Certain grant-supported clinical care programs (BCCEDP, Title X, etc.)
- State or local indigent care programs
- Workers' compensation
- Tricare, Trigon, public employees' insurance, etc.
- Contract sites
- CHIP
- Carved-out services
- Incarcerated patients
- Health IT/EHR personnel and costs
- Issuance of vouchers for payment of services
- New start or New Access Point
- Relationship between personnel on Table 5 and costs on Table 8A
- Relationship between insurance on Table 4 and revenue on Table 9D
- Relationship between prenatal care on Table 6B and deliveries on Table 7
- Relationship between race and ethnicity on Tables 3B and 7

CONTRACTED CARE (SPECIALTY, DENTAL, MENTAL HEALTH, ETC.)

Contracted care is services **paid for by the health center**.

Tables Affected	Treatment
5	Report providers (Column A) if the contract is for a portion of an FTE (e.g., one-day-a-week OB/GYN = 0.20 FTE). Always report visits (Column B or B2), regardless of method of provider payment or location of service (health center's service delivery site or contract provider's office). Services provided by contractors and paid for by or billed through the health center must meet the UDS countable visit definition to be counted on Table 5. DO NOT report FTE if the contract is for a service (e.g., $X per visit or $55 per resource-based relative value unit [RBRVU]), rather than provider time. DO NOT report FTE or visits if the contracted provider directly bills a third-party payer for the service.
6A	Report diagnoses and/or services provided, as applicable, from the encounter form or equivalent form received from the contract provider. Include contracted tests or procedures on Table 6A **only** if the listed services provided to patients are paid for by the health center or if their results are returned to the health center (or contract) provider to evaluate and provide results to the patient.
6B, 7	If a contract provider provides any services that are subject to clinical quality measures (CQMs), collect and report all data from the contractor (e.g., last HbA1c from an endocrinologist, sealants placed from a dentist).
8A	Column A, Accrued Cost: Report the cost of a provider/service on the applicable line. DO NOT report a "co-payment" or a "nominal fee" received by the provider from the patient. Report only the sum of what the health center pays. Column B, Facility and Non-Clinical Support Services: The health center will generally use a lower facility and non-clinical support services allocation rate for off-site services. Include all facility and non-clinical support costs in the direct charge (Column A) if the provider is off-site.
9D	Column A, Charge: The health center's UCR charge if on-site; use the contractor's UCR charge if off-site. Column B, Collection: The amount received by the health center and contractor from first and third parties. Column D, Adjustment: The amount disallowed by a third party for the charge (if on Lines 1–12). Column E, Sliding Fee Discount: The amount written off for eligible patients per the health center's fiscal policies (Line 13), if applicable. Calculate as UCR charge, minus amount collected from patients, minus amount owed by patients as their share of payment. DO NOT include payment by the health center here.

SERVICES PROVIDED BY A VOLUNTEER PROVIDER

Volunteers are not paid by the health center (although they may be paid by a third party) for services, which they provide on-site. This includes volunteer personnel (including AmeriCorps/HealthCorps, but not NHSC) who provide services on- or off-site on behalf of the health center. FTE can be included in the UDS Report when there is a basis for determining their hours.

Tables Affected	Treatment
5	Column A, FTE: Report FTE for services provided by volunteers on-site at the health center's service delivery site. FTE must be calculated. Use hours volunteered as the numerator. Because volunteers DO NOT receive paid leave benefits, the denominator is the number of hours that comparable personnel spend performing their job. Reduce a full-time schedule of 2,080 hours (for example) by vacation, sick leave, holidays, and continuing education normally provided to personnel. As a rule of thumb, use hours worked divided by a number somewhere around 1,800. DO NOT report providers who provide services at their own offices. Column B, Clinic Visits, and Column B2, Virtual Visits: Count visits for services provided at a service delivery site in the health center's scope of project and under its control. Include virtual visits when the volunteer provider is assigned to an approved service delivery location, providing services to health center patients, and documenting services in the health center's health IT/EHR.
6A	Report diagnoses and/or services provided on-site or virtually.
8A	Column C, Line 18: Report the value of the time donated by volunteers on this line **only**.
9D	The charges for their services are treated the same as for paid personnel. DO NOT include charges for volunteer providers who are off-site when those services are outside the scope of project and/or the control of the health center.

INTERNS AND RESIDENTS

Health centers often use individuals who are in training, referred to variously as interns or residents depending on their field and their licensing. Medical residents are generally licensed practitioners, while medical interns are generally NOT licensed. Some mental health interns, as well as other providers, may be licensed practitioners who are training for a higher level of certification or licensing.

Tables Affected	Treatment
5	Column A: Report licensed interns and residents in the credentialing category they are pursuing. For example, count a family practice resident on Line 1 as a Family Physician. Depending on the arrangement, FTEs may be calculated like any other personnel (if they are being paid by the health center) or like a volunteer (if they are not being paid). See volunteer providers above. Columns B and B2: Report visits between a medical resident or intern and a patient as visits to that resident or intern. DO NOT credit the visits to the supervisor of the resident or intern, unless an intern is unlicensed and the supervisor is legally responsible for the visit.
8A	If the intern or resident is paid by the health center or their cost is being paid through a contract that pays a third party for the interns or residents, report the cost in Column A on the appropriate line (Line 1 for medical, Line 5 for dental, etc.). If the health center is not paying an intern, resident, or third party, report the value of the donated time on Line 18. Be sure to describe the nature of the donation in the "Specify" line on Table 8A.

WOMEN, INFANTS, AND CHILDREN (WIC)

Tables Affected	Treatment
ZIP Code, 3A, 3B, 4	DO NOT report individuals whose only encounter with the health center is for WIC services (e.g., nutrition, health education, enabling services) and who receive no other services listed on Table 5 from providers outside of WIC.
5	Report FTE of personnel (Column A) on Line 29a. DO NOT report visits and patients (Columns B, B2, and C).
8A	Column A, Accrued Cost: Report the total net accrued cost of the program on Line 12 in Column A. Column B, Allocation of Facility and Non-Clinical Support Services: Since much of the non-clinical support services cost of the program will be included in the direct costs, it is presumed that overhead will be at a significantly lower rate. Do not include the value of WIC coupons as an accrued cost or donation.
9D	DO NOT report anything associated with the WIC program.
9E	Revenue for WIC programs, though originally federal, generally comes to health centers from the state, though some receive it from a lower-level intermediary. If the health center is receiving WIC funds from a state government, the grant/contract funds received go on Line 6. If the health center is receiving WIC funds from an intermediary, report the funds on Line 8. Specify the source of funds.

IN-HOUSE PHARMACY OR DISPENSARY SERVICES FOR HEALTH CENTER PATIENTS

Include only that part of the pharmacy that is paid by the health center and dispensed by in-house personnel (see below for other situations).

Tables Affected	Treatment
5	Column A, FTE: Report pharmacy personnel according to their role on Lines 23a–23d. If they have only an incidental responsibility to provide assistance in enrolling patients in PAPs, include them on the corresponding pharmacy Line 23a–23d. Include clinical pharmacists on Line 23b even if they spend time outside of the pharmacy. Report personnel other than pharmacists who spend time with PAPs on Line 27a, Eligibility Assistance. Columns B and B2, Visits: The UDS does NOT count encounters with pharmacy personnel as visits, whether it is for filling prescriptions or associated education or other patient/provider support. This is true for clinical pharmacists with expanded clinical privileges, as well. DO NOT count the administration or dispensing of medications as visits.
8A	Line 8a, Column A, Other Pharmacy Direct (Accrued) Costs: Report all operating costs of the pharmacy, *other than the cost of drugs*, on Line 8a. Include salaries, benefits, pharmacy computers, supplies, etc. Line 8b, Column A, Pharmaceutical Direct (Accrued) Costs: Place the actual cost of drugs the health center pharmacy bought on Line 8b. Include the cost of vaccines, contraceptives, injectable antibiotics, and other drugs dispensed in the health center but **NOT** in a pharmacy on Line 8b. The value of donated drugs is not reported here. That amount is reported on Line 18 in Column C. Line 11e, Column A, Eligibility Assistance Direct (Accrued) Costs: Report on Line 11e the cost of personnel (full-time, part-time, or allocated time) helping patients become eligible for PAPs and of all related supplies, equipment depreciation, etc. Column B, Facility and Non-Clinical Support Services: Report all facility and non-clinical support services costs associated with pharmacy and pharmaceuticals (Lines 8a and 8b) on Line 8a. Although there may be some facility and non-clinical support services costs associated with the actual purchase of the drugs, these costs are generally minimal when compared to the total cost of the drugs. Column C, Line 18: Report the value of donated drugs, including vaccines (generally calculated at 340B rates) and test kits, on this line only.
9D	Column A: Charge is the health center's full retail charge (generally larger than 340B rates) for dispensed drugs. Column B: Collection is the amount received from patients and/or other third parties/insurance companies. Column D: Adjustment is the amount a third party disallows for the charge (if on Lines 1–12). Column E: Sliding fee discount is the amount written off for eligible patients per health center policies (on Line 13). Calculate as retail charge, minus amount collected (if any) from patients or third-party payers, minus amount owed by patients (if any), as their share of payment.
9E	DO NOT report the value of donated drugs on this table; report on Table 8A, Line 18 (see Donated Drugs, Including Vaccines). The charges for drugs dispensed to patients go on Table 9D, **NOT** on Table 9E.

IN-HOUSE PHARMACY FOR COMMUNITY (I.E., FOR NON-PATIENTS)

Many health centers that own licensed pharmacies also provide services to members of the community at large who are not health center patients. Careful records must be maintained at these pharmacies to ensure that non-patients DO NOT receive drugs purchased under section 340B provisions. Some of these pharmacies are totally in scope, while others have their "public" portion out of scope. If the public aspect is out of scope, DO NOT report its activities on the UDS. If it is in scope, treat the public portion as an "other activity," as follows:

Tables Affected	Treatment
ZIP Code, 3A, 3B, 4	DO NOT include in the patient profile tables community members (non-patients) provided pharmaceuticals.
5	Column A, FTE: Allocate and report a portion of personnel who serve the public on Line 29a: Other Programs and Services.
8A	Line 12: Other Program-Related Services: Report all related personnel and pharmacy costs, including cost of pharmaceuticals.
9E	Line 10, Other Revenue: Report all revenue from public pharmacy and specify from "Public access pharmacy."

CONTRACT PHARMACY DISPENSING TO HEALTH CENTER PATIENTS, GENERALLY USING 340B PURCHASED DRUGS

Tables Affected	Treatment
5	DO NOT report personnel, visits, or patients for pharmacy dispensing.
8A	Report the amount the pharmacy charges for managing dispensing of drugs on Line 8a. Report the full amount paid for pharmaceuticals, either directly by the clinic or indirectly by the pharmacy, on Line 8b. If the pharmacy buys prepackaged drugs and there is no reasonable way to separate the pharmaceutical costs from the dispensing/administrative costs, report all costs on Line 8b. Associated non-clinical support services (overhead) costs will go on Line 8a in Column B, even if Line 8a Column A is blank. Report payments to pharmacy benefit managers on Line 8a. Share of profits and other fees: Some pharmacies engage in fee splitting and keep a share of profit. Report this as a payment to the pharmacy on Line 8a.
9D	Column A, Charge: Report the health center/contract pharmacy's full retail charge for the drugs dispensed. If retail is unknown, ask the pharmacy for retail prices for the drugs dispensed. Column B, Collection: Report the amount received by the contract pharmacy from patients or insurance companies. Health centers must collect this information from the contract pharmacy. (Note: Most health centers DO NOT have this sort of arrangement for Medicaid patients, unless explicitly stated.) Column D, Adjustment: Report the amount disallowed by a third party for the charge (if on Lines 1–12). Column E, Sliding Fee Discount: Report the amount written off for eligible patients per health center policies (Line 13). Calculate as retail charge (or pharmacy charge), minus amount collected (by pharmacy or health center) from patients, minus amount owed by patients as their share of payment.
9E	DO NOT report pharmacy revenue on Table 9E, and DO NOT use Table 9E to report net revenue from the pharmacy. Report actual gross revenue on Table 9D.

DONATED DRUGS, INCLUDING VACCINES

Tables Affected	Treatment
8A	If the drugs are donated to the health center and then dispensed to patients, report their value (generally calculated at 340B rates) on Line 18, Column C. If the drugs are donated directly to the patient, the health center is **not** required to report the value of the drugs; however, it is preferred that the value be included for a better understanding of the program.
9D	If the health center charges patients a dispensing fee, report only this amount and its collection and/or write-off.
9E	DO NOT report any amount, even though generally accepted accounting principles (GAAP) might suggest another treatment for the value.

CLINICAL DISPENSING OF DRUGS

Clinic areas of health centers dispense many pharmaceuticals, including vaccines, allergy shots, contraceptives, and MOUD. This may be a service associated with the visit or, in the case of vaccinations, a community service. These services DO NOT count as a visit, but charging patients for them is appropriate unless the clinic received the drugs for free.

Tables Affected	Treatment
3A, 3B, 4	DO NOT report these individuals as patients if this is the only service they received during the year.
5	DO NOT report these services as visits.
6A	DO NOT report these on Table 6A; they are not visits.
8A	Report drug costs on Line 8b, Pharmaceuticals (not on Line 3, Other Medical Costs). In the case of vaccines obtained at no cost through Vaccines for Children, HRSA (for COVID-19 vaccines, test kits, and supplies), or other state or local programs, report the value on Line 18, Donated Services and Supplies.
9D	Report full charges, collections, adjustments, and discounts, as appropriate. It is not appropriate to charge for a pharmaceutical that has been donated. However, an administration and/or dispensing fee *is* appropriate. Note that Medicare has separate flu vaccine rules.
9E	DO NOT report any amount.

ADHC AND PACE

Medicare, Medicaid, and certain other third-party payers often recognize ADHC programs. They involve caring for an infirm, frail, or elderly patient during the day to permit family members to work and to avoid institutionalization and preserve the health of the patient. They are quite expensive and may involve extraordinary per member per month (PMPM) capitation payments, but are cost effective compared to institutionalization. Patients who have both Medicare and Medicaid coverage are treated as Medi-Medi, as described below. PACE is even more expansive and may include ADHC services as well as services to maintain independence for the elderly.

Tables Affected	Treatment
3A, 3B, 4	Report the individuals seen during the year in ADHC and PACE programs as patients if one or more of their encounters are countable visits.
5	When a medical or mental health provider does a formal, separately billable examination of a patient at the ADHC/PACE facility, treat it as any other medical visit. DO NOT count the nursing, observation, monitoring, and dispensing of medication services that are bundled together to form an ADHC service as a visit for the purposes of reporting. Personnel are included on Line 29a, Other Programs and Services.
6A, 6B, 7	Report the clinical activity provided to patients at ADHC and PACE facilities, as appropriate, on the clinical tables.
8A	If the health center provides and bills medical services separately from the ADHC charge, report the associated costs on Lines 1–3. Report all other costs on Line 12. Similarly, include PACE costs for medical on Lines 1–3, pharmacy costs on Lines 8a–8b, and all other costs on Line 12.
9D	Report ADHC charges and collections on this table, generally as Medicaid and/or Medicare. Because of FQHC procedures, it is possible that there will also be significant positive or negative adjustments. In addition, see Medi-Medi, below.

MEDI-MEDI/DUALLY ELIGIBLE

Some individuals are eligible for and enrolled in both Medicare and Medicaid (commonly referred to as Medi-Medi or dually eligible). In this case, Medicare is primary and billed first. After Medicare pays its (usually FQHC-associated Z code or geographic-rate-adjusted) fee, the remainder is billed to Medicaid, which pays an amount based on policy that varies from state to state. In some states, the bill flows automatically from Medicare to Medicaid. In others, the bill is paid by Medicare with some portion denied, and then the service is rebilled to Medicaid as a secondary payer.

Tables Affected	Treatment
4	Report patients on Line 9, Medicare. DO NOT report as Medicaid. In addition, report these patients on Line 9a, Dually Eligible (Medicare and Medicaid); this line is a subset of the total reported on Line 9, Medicare.
9D	While the entire charge initially shows as a Medicare charge, after Medicare makes its payment, the remaining allowable amount is reclassified to Medicaid. Report the payment received from Medicaid on Line 1 in Column B. Report the difference between the charge and the collection as a positive or negative adjustment, depending on the amount. The health center must ensure that the charge is reclassified from Medicare to Medicaid. If your system does not reallocate the charge automatically, it should be done manually.

CERTAIN GRANT-SUPPORTED CLINICAL CARE PROGRAMS: BCCEDP, TITLE X, ETC.

Some programs pay providers on a fee-for-service or fee-per-visit basis under a contract, which may or may not also have a cap on total payments per grant period (usually the state fiscal year). They cover a very narrow range of services. Breast and cervical cancer early detection and family planning programs are the most common, but there are others.

These are fee-for-service or fee-per-visit programs only.

Tables Affected	Treatment
4	These programs are **NOT** insurance. They pay for a service, but health centers must classify patients according to their primary health insurance carrier. Most of these programs DO NOT serve insured patients, so most of the patients would be reported on Line 7 as uninsured.
9D	Although the patient is likely uninsured, there is an "Other Public" payer for the service. Report the health center's usual and customary charge for the service (NOT the negotiated fee paid by the public entity) on Line 7 in Column A and the payment in Column B. Because the payment will almost always be different from the charge, report the difference as an adjustment in Column D.
9E	DO NOT report the grant or contract covering the fee-for-service or fee-per-visit amount on Table 9E. Fully account for this on Table 9D.

STATE OR LOCAL INDIGENT CARE PROGRAMS

These pay for a wide range of clinical services through a state or local government grant earmarked for uninsured patients, generally those under an income limit. Most of these programs set payment caps and often make payments in a different fiscal year than that in which the patient received the service. IHS PL 93-638 Compact funds are included.

Tables Affected	Treatment
4	While patients may need to meet eligibility criteria, these programs are NOT public insurance. Count patients receiving care through these programs on Line 7 as uninsured, unless they have insurance.
9D	The health center's usual charges for each service are charged directly to patients (reported on Line 13, Column A). If patients pay any co-payment, report it in Column B. If they are responsible for a co-payment but DO NOT pay it, it remains a receivable until it is collected or is written off as bad debt in Column F. Report the portion of the charge not covered by the indigent care program or the patient's responsibility as a sliding fee discount in Column E.
9E	Report the total amount received during the calendar year from the state or local indigent care program or IHS PL 93-638 Compact fund on Line 6a and specify the source.

WORKERS' COMPENSATION

Workers' compensation is a form of liability insurance for employers and NOT health insurance for employees.

Tables Affected	Treatment
4	If workers' compensation covers a patient's bills, the patient usually has related insurance. Report that on Table 4 (even if the health center is not billing the insurance). Patients with work-related insurance go on Line 11 (Private). Those **without** any health insurance go on Line 7 (Uninsured).
9D	Report charges, collections, and adjustments for workers' compensation-covered services on Line 10 (Private Non-Managed Care).

TRICARE, TRIGON, PUBLIC EMPLOYEES' INSURANCE, ETC.

Many government employees have insurance.

Tables Affected	Treatment
4	Report them on Line 11 (Private), NOT on Line 10a. Note: Coverage directly through the Department of Veterans Affairs is a form of "Other Public" payment, **NOT** a form of medical insurance. Identify if the patient has primary medical insurance.
9D	Report charges, collections, and adjustments on Lines 10–12 (Private), **NOT** on Lines 7–9.

CONTRACT SITES

Some health centers have included in their scope of project a service delivery site (such as a school, workplace, or jail) where they provide services to patients at a contracted flat rate per session or other similar rate **that is not based on the volume of work performed**. The agreement generally stipulates whether and under what circumstances the health center may bill third parties.

Tables Affected	Treatment
4	Lines 1–6, Income: Obtain information on income from patients. In prisons, assume that all are at 100% and below FPG (Line 1). In schools, income should be that of the parent(s) or caregiver(s), or report as "Unknown." In the limited case of minor consent services, patients should be reported as below poverty. In the workplace, income is the patient's family/household income or, if not known, "Unknown" (Line 5). Lines 7–12, Insurance: Record the form of medical insurance the patient has, regardless of the health center's ability to bill that source. (Medicaid often covers children in school-based service sites even though they have another provider. Report these children as Medicaid patients.) The health center's contracting agency is not an insurer. Except for confidential minor consent services, it is not acceptable to assume that a student is uninsured.
5	Report all visits as appropriate. DO NOT reduce or reclassify personnel FTEs for travel time to and from contract sites.
8A	Costs will generally be considered medical (Lines 1–3) unless other services (dental, mental health, case management, etc.) are being provided. DO NOT report on Line 12: Other Related Services.
9D	Unless the health center charges a visit to a third party such as Medicaid, report the health center's usual and customary charges on Line 9, Column A (Other Public) if a government entity or Line 10, Column A (Private) if privately run. Report the amount paid by the contractor in Column B. Report the difference (positive or negative) in Column D (Adjustments).
9E	DO NOT report contract revenue on Table 9E.

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP provides health coverage to eligible children through Medicaid and/or separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Tables Affected	Treatment
4	Medicaid: If Medicaid handles CHIP and the enrolled patients are identifiable, report them on Line 8b. If it is not possible to differentiate CHIP administered through Medicaid from regular Medicaid, report the enrolled patients on Line 8a with other Medicaid patients. Non-Medicaid: Report CHIP-enrolled patients in states that DO NOT use Medicaid as "Other Public CHIP" on Line 10b. DO NOT report the enrollees on Line 11 (Private) even if a private insurance plan administers the program.
9D	Medicaid: Report on Lines 1–3, as appropriate. Non-Medicaid: Report on Lines 7–9 (Other Public), as appropriate. DO NOT report on Lines 10–12 (Private), even if a private insurance company administers the program.

CARVE-OUTS

Relevant to capitated managed care only: The health center has a capitated contract with an HMO that stipulates one set of CPT codes will be covered by the capitation fee, regardless of service frequency, and another set of codes (or all other codes) will be paid for by the HMO on a fee-for-service basis (the carve-outs) when appropriate. Most common carve-outs involve mental health, lab, radiology, and pharmacy, but may include specific specialty care or diagnoses (e.g., perinatal care or HIV).

Tables Affected	Treatment
4	Patient Member Months: Member months are reported on Line 13a in the appropriate column, regardless of whether the patient made use of services in any or all of those months. DO NOT report on Line 13b (fee-for-service managed care member months) for the carved-out services, regardless of payments received.
9D	Lines 2a/b, 5a/b, 8a/b, 11a/b: Report covered charges and related capitation payments on the "a" lines and carve-out charges and payments on the "b" lines. Report wraparound payments on both lines using the health center's allocation process.

INCARCERATED PATIENTS

Some health centers contract with jails or prisons to provide health services to inmates. These arrangements can vary in terms of the contractual arrangement and location for providing health services to patients. Also see Contract Sites, above.

Tables Affected	Treatment
4	Assume prisoners' individual income is at or below 100% FPG (Line 1). Unless the institution has arranged for inmate Medicaid enrollment, assume that inmates are uninsured.
9D	Report the health center's usual and customary charges for the service in Column A and the payments in Column B. Because the payment will almost always be different from the charge, report the difference as an adjustment in Column D. Assuming the jail or prison is billed for the patient's services, report on the following lines: • Line 7 (Other Public) if a government entity • Line 10 (Private) if privately run

Tables Affected	Treatment
9E	DO NOT report the grant or contract on Table 9E. Report revenue fully on Table 9D.

HEALTH IT/EHR PERSONNEL AND COSTS

Health IT, including EHR systems (some of which include an integrated PMS), record clinical activities and help providers manage and integrate patient services. As such, they are part of a QI program, though some aspects count in other service categories.

Tables Affected	Treatment
5	Include personnel who document services in the health IT/EHR, perform data entry, training, and technical assistance functions in the appropriate service category for which they perform these functions (e.g., scribes). DO NOT report as IT personnel or QI personnel. Report personnel members dedicating some or all of their time to design, operation, and oversight of QI systems; data specialists; statisticians; and health IT/EHR or medical form designers as QI personnel on Line 29b. Report personnel managing the hardware and software of a practice management billing and collection system as non-clinical support personnel under IT, Line 30c.
8A	Report costs for personnel who document services in the health IT/EHR or perform data entry, training, and technical assistance functions in the appropriate service category for which they perform these functions, **NOT** as IT personnel or QI personnel. Report costs associated with licenses, depreciation of the hardware and software, software support services, and annual fees for other aspects of the health IT/EHR on Line 3 (Other Medical). If the health IT/EHR covers dental and/or mental health, then appropriately allocate some of the costs to those lines as well. Report costs for personnel noted above as being included in QI on Line 12a. Report costs for personnel managing the hardware and software of a practice management billing and collection system as non-clinical support on Line 15.

ISSUANCE OF VOUCHERS FOR PAYMENT OF SERVICES

Voucher programs have traditionally been used by section 330(g) (MHC) programs to deliver primary and specialty care services to agricultural workers in geographically dispersed areas. Some homeless and other health center programs also use vouchers to outsource care they cannot provide in-house. This involves contracting with providers outside of the health center. Vouchers authorize a third-party provider to deliver the services and then submit the voucher to the health center for payment. Payment is generally less than the provider's full fee but consistent with other payers, such as Medicaid.

Tables Affected	Treatment
ZIP Code, 3A, 3B, 4	Report patients even if the only service they received was a paid vouchered service if these services would make the patient eligible for inclusion if the health center provided them. For example, a vouchered taxi ride or prescription would not make the individual "countable" because health centers DO NOT count transportation or pharmacy services on Table 5, but a vouchered eye exam *would* make the patient countable.
5	Column A: There is generally no way to account for the time of the voucher providers. As a result, report 0 FTEs for these services. If there is a provider who works at the health center, count the FTE of that provider. For example, count the one-day-a-week family practitioner who works on voucher at the health center as 0.20 FTEs on Line 1. Columns B and B2: Report all visits covered by voucher. DO NOT report visits where the referral is to a provider who is not paid for the service (e.g., a "voucher" to a doctor who donates five visits per week or one that pays a portion of the provider's fee with the rest being the patient's responsibility does not generate a visit on Table 5).
6A, 6B, 7	Diagnoses and Services: The voucher program should receive a bill from the provider, similar to a Health Care Financing Administration (HCFA)-1500, that lists the services and diagnoses. Health centers should track these and report them on Tables 6A, 6B, and 7.
8A	Cost of Vouchered Services: Report the costs on the appropriate service line(s). Report medical vouchers on Line 1 (NOT Line 3), dental vouchers on Line 5, etc. Report only those costs paid directly by the health center. Discounts: Virtually all clinical providers receive less than their full fee. Some health centers report the amount of these discounts as "donated services." While this is not required, health centers may report the difference between the voucher provider's full fee and the contracted voucher payment as a donated service on Line 18, Column C.
9D	Column A, Charges: Report the full charge that providers show on their HCFA-1500 on Line 13 (Self-Pay). DO NOT use the voucher amount as the full charge. Column B, Collections: If the patient paid the voucher program or provider a nominal or other fee, report this in Column B. Column E, Sliding Fee Discounts: Report the difference between the full charge and the amount that the patient was supposed to pay in Column E. DO NOT report the full amount in Column E if the patient should have paid the health center or voucher provider but did not complete payment. Column F, Bad Debt: Report any amount (such as a nominal fee) that the patient was supposed to pay to the health center but did not. Report bad debts according to the health center's financial policies. DO NOT report amounts that were due but not paid to the referral provider by the health center or a third-party payer.

NEW START OR NEW ACCESS POINT (NAP)

Health center grants or designations awarded for the first time (new start) may be added prior to October 1 during the calendar year. New starts must submit data for the full calendar year (covering January 1 to December 31). Health center service delivery sites may be added in scope of project at any point during the calendar year through a change in scope (CIS) request or a NAP award. Active, existing health centers are required to submit data for in-scope activities based on the CIS approval date and/or NAP site implementation date.

Tables Affected	Treatment
Patients by ZIP Code, 3A, 3B, 4	It is understood that a health center may have never collected some of the data required to be reported in the UDS prior to the start of Notice of Award, such as veteran status, member months in managed care, etc. Provide the best data available, but for the first year only, you may have some unusual numbers. Work with your UDS Reviewer to explain apparent data inconsistencies.
6B, 7	If the added service delivery site or health center will transition to a new health IT/EHR during the calendar year, gather the information for the year across the two systems and analyze them in a separate database to remove any duplication in the data.

RELATIONSHIP BETWEEN PERSONNEL ON TABLE 5 AND COSTS ON TABLE 8A

Personnel classifications should be consistent with cost classifications. The chart below illustrates the relationship between the two tables. The personnel on Table 5 are routinely compared to the costs on Table 8A during the review and analysis process. If there is a reason why such a comparison would look unusual (e.g., volunteers on Table 5 result in no cost on Table 8A or contractor costs on Table 8A with no corresponding FTEs on Table 5), include an explanation on Table 8A. Note that the cost categories on Table 8A are not in the same sequential order as the personnel categories on Table 5.

FTEs Reported on Table 5, Line:	Have Costs Reported on Table 8A, Line:
1–12: Medical Personnel	1: Medical Personnel
13–14: Medical Lab and X-ray	2: Medical Lab and X-ray
16–18: Dental	5: Dental
20a–20c: Mental Health	6: Mental Health
21: Substance Use Disorder	7: Substance Use Disorder
22: Other Professional	9: Other Professional
22a–22c: Vision	9a: Vision
23a–23d: Pharmacy	8a: Pharmacy
24–28: Enabling	11a–11h: Enabling
24: Case Managers	11a: Case Management
25: Health Education Specialists	11d: Health Education
26: Outreach Workers	11c: Outreach
27: Transportation Personnel	11b: Transportation
27a: Eligibility Assistance Workers	11e: Eligibility Assistance
27b: Interpretation Personnel	11f: Interpretation Services
27c: Community Health Workers	11h: Community Health Workers
28: Other Enabling Services	11g: Other Enabling Services
29a: Other Programs and Services	12: Other Program-Related Services
29b: Quality Improvement Personnel	12a: Quality Improvement
30a–30c and 32: Non-Clinical Support Services	15: Non-Clinical Support Services
31: Facility Personnel	14: Facility

RELATIONSHIP BETWEEN INSURANCE ON TABLE 4 AND REVENUE ON TABLE 9D

Revenue sources are generally aligned with patient insurance. The chart below illustrates the relationship between the two tables. The insurance on Table 4 (primary medical insurance as of the last visit) is routinely compared to the revenue on Table 9D (insurance payer at the time of each visit) during the review and analysis process. If there is a reason why such a comparison would look unusual (e.g., a large change in insurance coverage), include an explanation on Table 9D.

Primary Third-Party Medical Insurance on Table 4, Line:	Have Revenue Reported on Table 9D, Line:
7: Uninsured—No medical insurance at last visit (includes patients whose service is reimbursed through grant, contract, or indigent care funds)	13: Self-Pay—Include co-pays and deductibles, state and local indigent care programs **(DO NOT include revenues from programs with limited benefits; See Other Public, Lines 7–9)**
8a and 8b: Medicaid and Medicaid CHIP (includes Medicaid managed care plans and all forms of state-expanded Medicaid)	1–3: Medicaid (includes Medicaid expansion)
9: Medicare (includes Medicare Advantage)	4–6: Medicare
9a: Dually eligible (Medicare and Medicaid)	4–6: Medicare, initially, with balance reallocated to Medicaid
10a: Other Public non-CHIP—State and local government insurance that covers primary care	7–9: Other Public—Include patient service revenue from programs with limited benefits, such as family planning (Title X), EPSDT, BCCEDP, etc.
10b: Other Public CHIP (private carrier outside Medicaid)	7–9: Other Public
11: Private—Commercial insurance, including insurance purchased from state or federal exchanges (DO NOT include workers' compensation coverage as health insurance—it is a liability insurance)	10–12: Private—Charges and collections from contracts with private (commercial) carriers, private schools, private jails, Head Start, workers' compensation, and state and federal exchanges
13a: Capitated managed care enrollees	"a" lines
13b: Fee-for-service managed care enrollees	"b" lines

RELATIONSHIP BETWEEN PRENATAL CARE ON TABLE 6B AND DELIVERIES ON TABLE 7

The chart below illustrates the relationship and accounting of prenatal care patients and the birth outcomes to be reported on Tables 6B and 7. A "Yes" indicates that the information is to be reported in the specified table and section; "No" indicates the information is NOT to be reported. Because prenatal care and delivery may occur during different calendar years, it would be unusual for the count of prenatal care patients to equal the birth outcomes. The prenatal care patients on Table 6B are routinely compared to the deliveries and birth outcomes on Table 7 during the review and analysis process. If there is a reason why such a comparison would look unusual, include an explanation on the appropriate table.

Prenatal Care Patient and Birth Outcome Scenarios	Table 6B, Lines 1–9 (Age and Trimester of Entry)	Table 7, Column 1a (Patients who Delivered)	Table 7, Columns 1b–1d (Birth Outcomes—report each baby separately)
Patients still in prenatal care	Yes	No	No
Patients known to have delivered, with known birth outcomes	Yes	Yes	Yes
Patients known to have delivered, but birth outcomes unknown	Yes	Yes	No
Patients who miscarried	Yes	No	No
Patients with a stillbirth outcome	Yes	Yes	No
Patients lost to follow-up, birth outcomes unknown	Yes	No	No

Note: Health centers are expected to collect and report on birth outcomes of prenatal care patients. In situations where this information cannot be obtained, do not report an estimate.

RELATIONSHIP BETWEEN RACE AND ETHNICITY ON TABLES 3B AND 7

The patient population for each CQM on Table 7 is defined in terms of race and ethnicity, and comparisons are made to the race and ethnicity numbers reported on Table 3B. The following table illustrates the crosswalk between the comparable fields across the two tables.

Race	Ethnicity	Table 3B Reference	Table 7 Reference
Asian	Hispanic, Latino/a, or Spanish Origin	Line 1, Column A1–A5	Line 1a
	Not Hispanic, Latino/a, or Spanish Origin	Line 1, Column B	Line 2a
Asian Indian	Hispanic, Latino/a, or Spanish Origin	Line 1a, Column A1–A5	Line 1a1m, 1a1p, 1a1c, 1a1a, or 1a1o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1a, Column B	Line 2a1
Chinese	Hispanic, Latino/a, or Spanish Origin	Line 1b, Column A1–A5	Line 1a2m, 1a2p, 1a2c, 1a2a, or 1a2o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1b, Column B	Line 2a2
Filipino	Hispanic, Latino/a, or Spanish Origin	Line 1c, Column A1–A5	Line 1a3m, 1a3p, 1a3c, 1a3a, or 1a3o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1c, Column B	Line 2a3
Japanese	Hispanic, Latino/a, or Spanish Origin	Line 1d, Column A1–A5	Line 1a4m, 1a4p, 1a4c, 1a4a, or 1a4o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1d, Column B	Line 2a4
Korean	Hispanic, Latino/a, or Spanish Origin	Line 1e, Column A1–A5	Line 1a5m, 1a5p, 1a5c, 1a5a, or 1a5o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1e, Column B	Line 2a5
Vietnamese	Hispanic, Latino/a, or Spanish Origin	Line 1f, Column A1–A5	Line 1a6m, 1a6p, 1a6c, 1a6a, or 1a6o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1f, Column B	Line 2a6
Other Asian	Hispanic, Latino/a, or Spanish Origin	Line 1g, Column A1–A5	Line 1a7m, 1a7p, 1a7c, 1a7a, or 1a7o
	Not Hispanic, Latino/a, or Spanish Origin	Line 1g, Column B	Line 2a7
Native Hawaiian	Hispanic, Latino/a, or Spanish Origin	Line 2a, Column A1–A5	Line 1b1m, 1b1p, 1b1c, 1b1a, or 1b1o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2a, Column B	Line 2b1
Other Pacific Islander	Hispanic, Latino/a, or Spanish Origin	Line 2b, Column A1–A5	Line 1b2m, 1b2p, 1b2c, 1b2a, or 1b2o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2b, Column B	Line 2b2
Guamanian or Chamorro	Hispanic, Latino/a, or Spanish Origin	Line 2c, Column A1–A5	Line 1b3m, 1b3p, 1b3c, 1b3a, or 1b3o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2c, Column B	Line 2b3
Samoan	Hispanic, Latino/a, or Spanish Origin	Line 2d, Column A1–A5	Line 1b4m, 1b4p, 1b4c, 1b4a, 1b4o
	Not Hispanic, Latino/a, or Spanish Origin	Line 2d, Column B	Line 2b4
Black or African American	Hispanic, Latino/a, or Spanish Origin	Line 3, Column A1–A5	Line 1cm, 1cp, 1cc, 1ca, or 1co
	Not Hispanic, Latino/a, or Spanish Origin	Line 3, Column B	Line 2c
American Indian/Alaska Native	Hispanic, Latino/a, or Spanish Origin	Line 4, Column A1–A5	Line 1dm, 1dp, 1dc, 1da, or 1do
	Not Hispanic, Latino/a, or Spanish Origin	Line 4, Column B	Line 2d

Race	Ethnicity	Table 3B Reference	Table 7 Reference
White	Hispanic, Latino/a, or Spanish Origin	Line 5, Column A1–A5	Line 1em, 1ep, 1ec, 1ea, or 1eo
	Not Hispanic, Latino/a, or Spanish	Line 5, Column B	Line 2e
More than One Race	Hispanic, Latino/a, or Spanish Origin	Line 6, Column A1–A5	Line 1fm, 1fp, 1fc, 1fa, or 1fo
	Not Hispanic, Latino/a, or Spanish Origin	Line 6, Column B	Line 2f
Unreported/Chose Not to Disclose Race	Hispanic, Latino/a, or Spanish Origin	Line 7, Column A1–A5	Line 1gm, 1gp, 1gc, 1ga, or 1go
	Not Hispanic, Latino/a, or Spanish Origin	Line 7, Column B	Line 2g
Unreported/Chose Not to Disclose Race	Unreported/Chose Not to Disclose Ethnicity	Line 7, Column C	Line h

Appendix C: Reduced Number of Records Reviewed for Clinical Quality Measure Reporting

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

Data from health centers' electronic health record (EHR) systems are increasingly being used to report on the full denominator of patients whose characteristics fulfill UDS clinical quality measure (CQM) specifications. The option of using a chart sampling method (i.e., a scientifically drawn random sample of 70 patient charts) for reporting CQMs on Tables 6B and 7 is no longer available for UDS reporting. Using EHR data to report UDS clinical quality measures among all patients for which each CQM applies allows for a more complete understanding of health centers' clinical quality performance and patient health status.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

For each measure discussed on Tables 6B and 7 (except the perinatal measures), health centers have the option of reporting on their entire patient population as the Number of Records Reviewed (Column B) or a reduced denominator consisting of a minimum of 80% of all eligible patients, as defined by the measure steward for each CQM, from all service delivery sites and grant-funded programs. While a reduced number of records reviewed is permitted, a full EHR or health information technology (health IT) system reporting is preferred. Although a reduced denominator is permitted for the Number of Records Reviewed (Column B), health centers must be able to report on the total patients to be assessed for the measure (denominator, Column A) using their EHR or health IT system.

Note: Data source must cover the measurement period (e.g., 5 years for Pap tests, 2 years for immunizations) and include information to assess meeting the numerator criteria with the CQM and to evaluate exclusions.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

A reduced denominator generally provides the ability to facilitate accurate reporting if all conditions of individual CQM requirements are met. You may only report a reduced denominator (Number of Records Reviewed, Table 6B, Column B; and Table 7, Columns 2b, and 3b) if the factors that required its use are unrelated to the measure variables outlined in measure-specific reporting requirements on Tables 6B and 7.If you DO NOT have an EHR or health IT system in place or are unable to report results for a minimum of 80% of all patients eligible for the CQM from all service delivery sites, please contact the UDS Support Center to discuss reporting options.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

Appendix D: Health Center Health Information Technology (Health IT) Capabilities

INTRODUCTION

The Health IT Capabilities Form collects information through a series of questions on the health center's health IT capabilities, including EHR interoperability and eligibility for CMS Promoting Interoperability programs. The Health IT Capabilities Form must be completed and submitted as part of the UDS submission. The form includes questions about the health center's implementation of an EHR, certification of systems, and how widely adopted the system is throughout the health center and its providers.

Major changes from the 2023 calendar year reporting to 2024 calendar year reporting include:

There are no major changes to this form.

QUESTIONS

The following questions appear in the EHBs. Complete them before you file the UDS Report. Reporting requirements for the health IT questions are on-screen in the EHBs as you complete the form. Respond to each question based on your health center status **as of December 31, 2024**.

1. Does your health center currently have an electronic health record (EHR) system installed and in use, at a minimum, for medical care, by December 31?

a. Yes, installed at all service delivery sites and used by all providers

- For the purposes of this response, "providers" mean all medical providers, including physicians, nurse practitioners, physician assistants, and certified nurse midwives.
- Although some or all of the dental, mental health, or other providers may also be using the system, as may medical support personnel, this is not required to choose response (a).
- For the purposes of this response, "all service delivery sites" means all permanent service delivery sites where medical providers serve health center medical patients.
- It DOES NOT include administrative-only locations, hospitals or nursing homes, mobile vans, or sites used on a seasonal or temporary basis.
- You may check this option if a few newly hired, untrained personnel are the only ones not using the system.

b. Yes, but only installed at some service delivery sites or used by some providers

- Select option (b) if one or more permanent service delivery sites did NOT have the EHR installed or in use (even if this is planned), or if one or more medical providers (as defined on this page under [a]) do not yet use the system.
- When determining if all providers have access to the system, the health center should also consider part-time and locum providers who serve clinic patients.
- DO NOT select this option if the only medical providers who did not have access were those who were newly hired and still being trained on the system.

c. No

- Select "no" if no EHR was in use on December 31, even if you had the system installed and training had started.
- If the health center purchased an EHR but has not yet put it into use, answer "no."

If response is "c. No," skip to Question 11. If response is "a" or "b," continue to next question.

If more than one medical EHR is used, answer "Yes," to Question 1 and select "a" if they are used at all service delivery sites and used by all providers or select "b" if they are used at some service delivery sites or used by some providers.

If "Yes, but only installed at some service delivery sites or used by some providers" is selected, a box expands for health centers to identify how many service delivery sites have the EHR in use and how many (medical) providers are using it. Please enter the number of service delivery sites (as defined under question 1) where the EHR is in use and the number of providers who use the system (at all service delivery sites). Include part-time and locum medical providers who serve clinic patients. Count a provider who has separate login identities at more than one service delivery site as just one provider.

This next set of questions seeks to determine whether the health center installed an EHR by December 31 and, if so, which product was in use, how broad system access was, and what features were available and in use. DO NOT include PMS or other billing systems, even though they can often produce much of the UDS data.

If a system is in use (i.e., if [a] or [b] has been selected), indicate whether it has been certified by the Office of the National Coordinator—Authorized Testing and Certification Bodies.

1a. Is your system certified by the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program?

a. Yes

b. No

Health centers are to indicate the vendor, product name, version number, and ONC-certified health IT product list number. This information is available on the Certified Health IT Product List (CHPL). Select the most current version number being used. If you have more than one EHR (if, for example, you acquired another practice with its own EHR), report the EHR that will be the successor system or the EHR used for capturing primary medical care.

1a1. Vendor

1a2. Product Name

1a3. Version Number

1a4. ONC -certified Health IT Product List Number

Note: The CHPL Number is a standardized number that reflects your certified product and version. Step-by-step instructions for using the CHPL to find your system are available in the CHPL Public User Guide.

1b. Did you switch to your current EHR from a previous system this year?

a. Yes

b. No

1c. Do you use more than one EHR, data collection, and/or data analytics system across your organization? Select "Yes" if the health center has more than one EHR that flows into one central health IT/EHR or practice management system.

a. Yes

b. No

1c1. If yes, what is the reason?

a. Additional EHR/data system(s) are used during transition from one primary EHR to another
b. Additional EHR/data system(s) are specific to one service type (e.g., dental, behavioral health, care coordination)
c. Additional EHR/data system(s) are used at specific service delivery sites with no plan to transition
d. Additional EHR/data system(s) are used for analysis and reporting (such as for clinical quality measures or custom reporting)
e. Other (please describe _____)

1d. Question removed.

1e. Question removed.

2. Question removed.
3. Question removed.
4. Which of the following key providers/health care settings does your health center electronically exchange clinical or patient information with? (Select all that apply.)
   a. Hospitals/Emergency rooms
   b. Specialty providers
   c. Other primary care providers
   d. Labs or imaging
   e. Health information exchange (HIE)[33]
   f. Community-based organizations/social service partners
   g. None of the above
   h. Other (please describe _____)
5. Does your health center engage patients through health IT in any of the following ways? (Select all that apply.)
   a. Patient portals
   b. Kiosks
   c. Secure messaging between patient and provider
   d. Online or virtual scheduling
   e. Automated electronic outreach for care gap closure or preventive care reminders
   f. Application programming interface (API) patient access to their health record through mHealth apps[34]
   g. Other (please describe _____)
   h. No, we DO NOT engage patients using health IT
6. Question removed.

[33] HIEs are typically state or regional data exchanges that support information sharing between different organizations, provider types, and technology vendors. More information on HIEs can be found on the Health Information Exchange webpage.
[34] More information on How APIs in Health Care can Support Access to Health Information: Learning Module

7. Question removed.
8. Question removed.
9. Question removed.
10. How does your health center utilize health IT and EHR data beyond direct patient care? (Select all that apply.)
    a. Quality improvement
    b. Population health management
    c. Program evaluation
    d. Research
    e. Other (please describe _____)
    f. We DO NOT utilize health IT or EHR data beyond direct patient care
11. Does your health center collect data on individual patients' social risk factors, outside of the data countable in the UDS?

    Note: Health centers should respond "a. Yes" below only if they are screening for social risks, meaning they have a consistent set of questions that are asked of individual patients uniformly for the purposes of collecting information on the non-medical, health-related social needs of patients, such as housing instability and/or food insecurity, **beyond** those demographic patient characteristics captured elsewhere on the UDS Report. Collecting race, ethnicity, and/or income level would not be considered here as collecting data on individual patients' social risk factors, as this information is already counted in the UDS Report, on Tables 3B and 4. Similarly, collecting data on intimate partner violence, domestic violence, and/or human trafficking would not be considered, as this information is already counted in the UDS Report, on Table 6A.

    a. Yes
    b. No, but we are in planning stages to collect this information
    c. No, we are not planning to collect this information

    If response to Question 11 is "a," then continue to the next question. If response is "b" or "c," skip to Question 12b.

11a. How many health center patients were screened for social risk factors using a standardized screener during the calendar year? (Only respond to this if the response to Question 11 is "a. Yes.") _____

12. Which standardized screener(s) for social risk factors, if any, did you use during the calendar year? (Select all that apply. Only respond to this if your response to Question 11a is greater than 0.)
    a. Accountable Health Communities Screening Tools
    b. Upstream Risks Screening Tool and Guide
    c. IHELLP
    d. Recommend Social and Behavioral Domains for EHRs
    e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
    f. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)
    g. WellRx
    h. Health Leads Screening Toolkit
    i. Other (please describe: _____)

Note: Health centers that are screening for social risks, using the definition noted in Question 11, but are NOT using one of the standardized screening tools listed should respond "i. Other." Specify that you are using standardized questions from various screening tools.

j. We DO NOT use a standardized screener (response to Question 12b is required when selected)

Note: Only select "j. We DO NOT use a standardized screener" if you DO NOT use a consistent set of questions/approach to screen patients for social risks. If Question 11a is greater than 0 and the health center responds to Question 12, continue to the next question. If Question 11a is 0 and Question 12 is any option other than "j," skip to Question 13.

12a. Of the total patients screened for social risk factors (Question 11a), please provide the total number of patients that screened positive for any of the following at any point during the calendar year. (A patient may experience multiple social risks and should be counted once for each risk factor they screened positive for, regardless of the number of times screened during the year.)

a. Food insecurity _____

b. Housing insecurity _____

c. Financial strain _____

d. Lack of transportation/access to public transportation _____

12b. If you DO NOT use a standardized screener to collect this information, please indicate why. (Select all that apply.) (Only respond to this question if your response to Question 11a is "zero" or if Question 12, option j is selected.)

a. Have not considered/unfamiliar with standardized screeners

b. Lack of funding for addressing these unmet social needs of patients

c. Lack of training for personnel to discuss these issues with patients

d. Inability to include with patient intake and clinical workflow

e. Not needed

f. Other (please describe _____)

13. Does your health center integrate a statewide Prescription Drug Monitoring Program (PDMP) database into the health information systems, such as health information exchanges, EHRs, and/or pharmacy dispensing software (PDS) to streamline provider access to controlled substance prescriptions?

a. Yes

b. No

c. Not sure

FAQ FOR APPENDIX D: HEALTH CENTER HEALTH IT CAPABILITIES FORM

1. What do we do if our health center acquired a new EHR system and we need to use two different systems to report a full calendar year UDS Report?

Health centers are required to submit one UDS Report that includes unduplicated data for the entire scope of services included in the grant or designation for the calendar year. It is expected that health centers that transition from one EHR to another during the reporting year are able to report unduplicated counts of patients, visits, and other activity, as appropriate. To complete the UDS Report as accurately as possible, your health center will need to have access to both systems and merge results. Health centers should work to

establish a process to pull and transfer data from the previous EHR system during the merger process. This may require pulling data from the two systems into a separate database to remove any duplication in the data. This can be a time-consuming process and it is recommended that health centers begin this process as soon as the year ends or once the transition has been completed to ensure sufficient time for completion prior to the submission due date.

2. **We use multiple EHRs across our health center that are then aggregated into a single analytics platform or data warehouse for UDS reporting. How should we be responding to the questions on this form?**

   Respond to Question 1 and its sub-questions 1a through 1c1 based on the primary EHR used by your medical providers. For example, provide the vendor, product, product number, and CHPL Number for the primary EHR used by your medical providers.

   Respond to Questions 4 through 10 based on your entire EHR and health IT ecosystem. Your responses should state where data are exchanged from any of the systems in use at your health center and for what purposes the data from those systems are used.

3. **We combined a few different social risk screeners to do social risk screening of patients (such as to meet various grant or payer requirements or address unique needs of the community). How do we report this on Questions 11 through 12b?**

   Respond "a. Yes" to Question 11 and select "i. Other" on Question 12. Describe the screening tool that you use in the specify field of Question 12 (for example, describe the screeners that have been combined or note that a screener was provided by your MCO). Also, report the total number of health center patients screened using the particular tool(s) you use in Question 11a, and, of those screened, how many screened positive in each of the four areas specified in Question 12a. If your screener does NOT have a question related to any of the four areas specified in Question 12a, enter "0" for that area.

4. **Do people reported on Line 11a (count of those screened for social risk factors) need to have a countable visit on Table 5?**

   Yes. This count should only include **health center patients** who were screened for social risk. Patients are reported as having had at least one countable visit on Table 5 and are included in the total patient count on the patient demographics tables (ZIP Code Table and Tables 3A, 3B, and 4). This number cannot exceed total patients and is generally a subset of that count.

Appendix E: Other Data Elements

INTRODUCTION

The questions on the Other Data Elements Form collect information on the changing landscape of health centers to include expanded services and delivery systems.

The text directly below indicates changes from 2023 calendar year reporting to 2024 calendar year reporting:

A notable change has been made to the Other Data Elements Form, as outlined below:

- A new question has been added to collect the number of patients screened for family planning needs, including contraceptive methods, using a standardized screener during the calendar year.

This marks the conclusion of changes from 2023 calendar year reporting to 2024 calendar year reporting.

QUESTIONS

Topics on this form include medications for opioid use disorder (MOUD), telehealth, and outreach and enrollment assistance. Respond to each question based on your health center status **as of December 31, 2024**.

1. Medications for Opioid Use Disorder (MOUD)
   a. How many providers, on-site or with whom the health center has contracts, treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) (i.e., buprenorphine, methadone, naltrexone) for that indication during the calendar year?
   b. During the calendar year, how many patients received MOUD for opioid use disorder from a provider accounted for in Question 1a?
2. Did your organization use telemedicine to provide remote (virtual) clinical care services?

   Note: Telemedicine services refers to remote clinical services for patients.

   a. Yes

   If "Yes" is selected, proceed to questions 2a1–2a3.

   2a1. Who did you use telemedicine to communicate with? (Select all that apply.)
      a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations)
      b. Specialists outside your organization (e.g., specialists at referral centers)

   2a2. What telehealth technologies did you use? (Select all that apply.)
      a. Real-time telehealth (e.g., live videoconferencing)
      b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)
      c. Remote patient monitoring
      d. Mobile Health (mHealth)

2a3. What primary telemedicine services were used at your organization? (Select all that apply.)

a. Primary care
b. Oral health
c. Behavioral health: Mental health
d. Behavioral health: Substance use disorder
e. Dermatology
f. Chronic conditions
g. Disaster management
h. Consumer health education
i. Provider-to-provider consultation
j. Radiology
k. Nutrition and dietary counseling
l. Other (Please describe _____)

b. No.

If you did not have telemedicine services, please comment on why. (Select all that apply.)

a. Have not considered/unfamiliar with telehealth service options
b. Policy barriers (Select all that apply.)
    i. Lack of or limited reimbursement
    ii. Credentialing, licensing, or privileging
    iii. Privacy and security
    iv. Other (Please describe _____)
c. Inadequate broadband/telecommunication service (Select all that apply.)
    i. Cost of service
    ii. Lack of infrastructure
    iii. Other (Please describe _____)
d. Lack of funding for telehealth equipment
e. Lack of training for telehealth services
f. Not needed
g. Other (Please describe _____)

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (personnel, contracted personnel, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about third-party primary care health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

   Enter number of assists _____

Note: Assists DO NOT count as visits on the UDS tables.

- How many health center patients were screened for family planning needs, including for contraceptive methods, using a standardized screener during the calendar year? _____

FAQ FOR APPENDIX E: OTHER DATA ELEMENTS FORM

1. What is considered a standard screener for the family planning response?

Use of a standardized screener tool (i.e., a consistent set of questions that are asked of individual patients uniformly for the purposes of collecting information to assess the individual's family planning needs or interest in contraceptive services).

Appendix F: Workforce

INTRODUCTION

The Workforce Form collects information through a series of questions on health center workforce. It is important to understand the current state of health center workforce training and staffing models to better support recruitment and retention of health center professionals.

There are no major changes to this form.

QUESTIONS

Report on these data elements as part of your UDS submission. Topics include health professional education/training (DO NOT include continuing education units) and satisfaction surveys. Respond to each question based on your health center status **as of December 31, 2024**.

1. Does your health center provide any health professional education/training that is a hands-on, practical, or clinical experience?
   a. Yes
   b. No

1a. If yes, which category best describes your health center's role in the health professional education/training process? (Select all that apply.)
   a. Sponsor[35]
   b. Training site partner[36]
   c. Other (please describe _____)

2. If yes, please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category[37] within the calendar year. (Do not answer this question if your response to question 1 was No).

   Note: Line 1, below, is the count of individuals, regardless of their specialty. Lines 1a–1f are to account for the multiple specialties that an individual has received or may be receiving training for during the calendar year (e.g., an Internist + other specialty).

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
Medical		
1. Physicians		
a. Family Physicians	<cell not reported>	
b. General Practitioners	<cell not reported>	
c. Internists	<cell not reported>	
d. Obstetrician/Gynecologists	<cell not reported>	

[35] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).
[36] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).
[37] Examples of pre-graduate/certificate training include student clinical rotations or externships. A residency, fellowship, or practicum would be examples of post-graduate training. Include non-health-center individuals trained by your health center.

	a. Pre-Graduate/Certificate	b. Post-Graduate Training
e. Pediatricians	<cell not reported>	
f. Other Specialty Physicians	<cell not reported>	
2. Nurse Practitioners		
3. Physician Assistants		
4. Certified Nurse Midwives		
5. Registered Nurses		
6. Licensed Practical Nurses/ Vocational Nurses		
7. Medical Assistants		
Dental		
8. Dentists		
9. Dental Hygienists		
10. Dental Therapists		
10a. Dental Assistants		
Mental Health and Substance Use Disorder		
11. Psychiatrists	<cell not reported>	
12. Clinical Psychologists		
13. Clinical Social Workers		
14. Professional Counselors		
15. Marriage and Family Therapists		
16. Psychiatric Nurse Specialists		
17. Mental Health Nurse Practitioners		
18. Mental Health Physician Assistants		
19. Substance Use Disorder Personnel		
Vision		
20. Ophthalmologists		
21. Optometrists		
Other Professionals		
22. Chiropractors		
23. Dieticians/Nutritionists		
24. Pharmacists		
25. Other (please describe _____)		

3. Provide the number of health center personnel serving as preceptors at your health center: ____
4. Provide the number of health center personnel (non-preceptors) supporting ongoing health center training programs: ____
5. How often does your health center conduct satisfaction surveys to **providers** (as identified in Appendix A, Listing of Personnel) working for the health center? Report only provider surveys here. (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We DO NOT currently conduct provider satisfaction surveys
   e. Other (please describe _____)

6. How often does your health center conduct satisfaction surveys for general personnel (as identified in Appendix A, Listing of Personnel) working for the health center (report provider surveys in question 5 only)? (Select one.)
   a. Monthly
   b. Quarterly
   c. Annually
   d. We DO NOT currently conduct personnel satisfaction surveys
   e. Other (please describe _____)

Appendix G: De-Identified Patient-Level Reporting

INTRODUCTION

High-quality accessible data are critical to strategically meeting the needs of patients and identifying opportunities for clinical process improvement. The growth in health information technology, coupled with the increased adoption of EHRs, has transformed patient care delivery and underscored the need for a secure and rapid exchange of health data between disparate systems.

Health Level Seven International (HL7®) developed Fast Healthcare Interoperability Resources (FHIR®) version release 4 (R4) to standardize the electronic exchange of patient data across systems. FHIR R4 has the flexibility to support a variety of use cases and enhances interoperability by transmitting health data rapidly and more securely than ever before. It is important for the collection of UDS data to align with interoperability standards and reporting requirements across HHS and the health care industry. Leveraging FHIR R4 to collect UDS de-identified patient-level data will improve data granularity, allow for the development of robust patient management programs, and improve equitable access to high-quality, cost-effective primary care services. The transition to de-identified patient-level data reporting using FHIR R4 interoperability standards is part of the natural evolution of health information technology (health IT).

In addition to aggregate UDS reporting within EHBs, health centers are asked to submit certain de-identified patient-level data (UDS+) using FHIR. Details on the minimum submission requirements will be announced on the UDS Modernization Initiative and Health Center Program Community[38] websites. The aggregate report submitted in EHBs will be the submission of record for calendar year 2024 UDS reporting.

SCOPE OF UDS+

All health centers are to submit a full UDS Report within EHBs by February 15, 2025.

In addition to an aggregate UDS Report submission within EHBs, health centers may submit de-identified patient-level data (UDS+) submitted using HL7 FHIR R4 standards for UDS for the data elements on the following tables:

- Patients by ZIP Code Table
- Table 3A: Patients by Age and by Sex
- Table 3B: Demographic Characteristics
- Table 4: Selected Patient Characteristics
- Table 6A: Selected Diagnoses and Services Rendered
- Table 6B: Quality of Care Measures
- Table 7: Health Outcomes

Health centers reporting UDS+ data will submit through (bulk) FHIR R4 APIs, using the UDS+ FHIR Implementation Guide (IG). To learn more about UDS+, including the timeline for submission, please refer to the Health Center Program Community website. Review the UDS+ FHIR IG, as well as the UDS Modernization Initiative and UDS Modernization FAQ webpages, for UDS+ reporting details.

[38] Login credentials are required. Users may request access through the Health Center Program Community.

REPORTING UDS+ DATA

The UDS+ utilizes FHIR and the United States Core Data for Interoperability (USCDI) R4 to increase the utility of UDS Report data and to reduce the annual reporting burden by aligning with interoperability standards and reporting requirements used across the U.S. Department of Health and Human Services and within the health care industry. The UDS+ FHIR Implementation Guide (IG) defines the set of rules by which health centers can report UDS+ de-identified patient data to HRSA through FHIR R4 APIs. The UDS+ FHIR IG provides well-defined capability statements, FHIR R4 operations, FHIR R4 profiles, FHIR R4 extensions, and terminology needed to implement UDS+.

The UDS+ FHIR IG aligns HRSA reporting requirements with the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS) regulations to the extent possible.

Note: Data submitted through UDS+ must **NOT** include protected health information or identifiable patient data for successful submission.

RESOURCES AND SUPPORT FOR UDS+ REPORTING

Several resources are available to assist health centers with the use of FHIR R4 standards for UDS reporting:

ONC Resources

Topic and Link	Description
21st Century Cures Act Final Rule: Interoperability, Information Blocking, and the ONC Health IT Certification Program	Federal administrative regulation published in the Federal Register that implements certain provisions of the Cures Act related to advancing EHR interoperability and is designed to give patients and their health care providers secure access to health information.
Certification of Health IT	Webpages describing elements of ONC's Health IT Certification Program, including the program requirements, certification process, and certified health IT product list.
FHIR® API	Interface that allows a computer program or system to access and exchange data across systems. APIs define the data structure, format of the data, and accepted system interactions.
FHIR® Fact Sheets	Four fact sheets developed by ONC and Health Level Seven International (HL7®) to demystify FHIR® for health care providers and administrators.
United States Core Data for Interoperability (USCDI)	A standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.

HL7® Resources

Topic and Link	Description
Bulk Data Access Implementation Guide (IG)	Overview of the purpose and use cases for a Bulk Data FHIR® IG.
HL7® FHIR® Implementation Guidance Checklist	Assists in navigating available resources for the adoption of HL7® FHIR® standards and API-based approaches to interoperability.
HL7® FHIR® Resource Index	A page for finding FHIR® specification resources by category and alphabetically.
HL7® Standards	Homepage for HL7®, a not-for-profit, American National Standards Institute (ANSI)-accredited standards developing organization, which provides a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information.

Topic and Link	Description
US Core Implementation Guide	Homepage for the US Core Implementation Guide, which defines the minimum set of constraints on the FHIR R4 resources to create the US Core Profiles.

HRSA's BPHC Webpages

Topic and Link	Description
UDS Modernization Frequently Asked Questions	The webpage that provides answers to health center personnel and stakeholder FAQ about the overall initiative, including UDS+.
UDS Modernization Initiative	A webpage that provides the purpose, goals, objectives, and activities of the UDS Modernization Initiative, including UDS Patient-Level Submission (UDS+).
Health Center Program Community	Homepage for the Health Center Program Community, which includes UDS+-related resources, including the UDS+ FHIR IG, which defines the health IT architectural details and technical specifications by which health centers can report the UDS+ de-identified patient data to HRSA using APIs.
UDS+ FHIR Implementation Guide (IG)	The Implementation Guide (IG) defines the specifications by which Health Center Program awardees and look-alikes can report de-identified patient-level data to HRSA to meet UDS reporting requirements using FHIR.

Please visit the Health Center Program Community[39] website to access more information about UDS+, including the UDS+ FHIR IG, resources, and FAQ.

[39] Login credentials are required. Users may request access through the Health Center Program Community.

Appendix H: Health Center Resources

Several resources are available to assist health centers with UDS reporting criteria, UDS+, or EHBs system questions:

Description	Contact	Email or Web Form	Phone
UDS reporting questions	UDS Support Center	udshelp330@bphcdata.net or BPHC Contact Form Select: Uniform Data System (UDS) > UDS Reporting and > the most applicable subcategory	866-837-4357 (866-UDS-HELP)
EHBs account and user access questions	Health Center Program Support	BPHC Contact Form Select: Technical Support > EHBs Tasks/Technical Issues > EHBs Privileges	877-464-4772
EHBs technical issues with UDS Reports	Health Center Program Support	BPHC Contact Form Select: Technical Support > EHBs Tasks/Technical Issues > Other EHBs Submission Types	877-464-4772
UDS+ FHIR IG and API (UDS Modernization) technical support	Health Center Program Support	BPHC Contact Form Select: Uniform Data System (UDS) > UDS Modernization > Patient-level Submission (UDS+)	877-464-4772

Visit HRSA's BPHC UDS Training and Technical Assistance webpage to access this manual and other data and resources, including:

- a complete set of the UDS tables and forms (note that the table view within EHBs may look different but contains the same fields),
- notifications of changes to reporting criteria included in the PAL,
- training opportunities, and
- other reporting materials and guidance.

Visit HRSA's BPHC UDS Modernization Initiative overview, Frequently Asked Questions, or UDS Test Cooperative pages to access information about UDS Patient-Level Submission (UDS+).

Subscribe to the Primary Health Care Digest for timely updates and reminders about UDS reporting.

Visit HRSA's BPHC Strategic Partnerships webpage for descriptions and lists of Health Center Controlled Networks (HCCNs), National Training and Technical Assistance Partners, and Primary Care Associations (PCAs) that may assist health centers with UDS reporting.

UDS PRODUCTION TIMELINE AND REPORT AVAILABILITY

Health centers can access their current-year and prior-year UDS Reports, as well as several standard reports, through the EHBs web link.

- UDS Preliminary Reporting Environment (PRE): October–December 2024
- UDS annual data collection and reporting: January 1–February 15, 2025
- Deadline for submitting a complete UDS Report: February 15, 2025
- UDS reporting freeze: March 31, 2025
- Standard UDS Reports are available in EHBs, as shown below.

UDS Report Level	Timing	Description	Awardee	Look-Alike	PCAs & HCCNs
Finalized Health Center Tables and XML Data File	June	Provides health center with data for each of the 11 UDS tables, the Health IT, Other Data Elements, and Workforce forms	HC	HC	HC
Health Center Trend Report	July/August	Compares the health center's performance for key measures (in three categories: Access, Quality of Care/Health Outcomes, and Financial Cost/Viability) with national and state averages over a 3-year period	HC, S, N	HC, N	HC, S, N
UDS Summary Report	July/August	Summarizes and analyzes the health center's current UDS data using measures across various tables of the UDS Report	HC, S, N	HC, N	HC, S, N
UDS Rollup Report	July/August	Compiles annual data reported by health centers and provides summary data for patient characteristics, socioeconomic characteristics, staffing, patient diagnoses and services rendered, quality of care, health outcomes, financial costs, and revenue	S, N	N	S, N
Performance Comparison Report	September	Summarizes and analyzes the health center's latest UDS data, giving details at awardee, state, national, urban, and rural levels with trend comparisons and percentiles	HC, S, N	HC, N	HC, S, N

Abbreviations indicate geographies and detail level for which each report is available.

HC=Health Center, S=State, N=National

PUBLICLY AVAILABLE UDS DATA

Finalized UDS data is available to the public, as shown below.

- UDS state and national summary tables and Health Center Program awardee and look-alike data profiles will be available in the HRSA Data Warehouse in August 2025.
- Service area data will be available on the HRSA Data and Reporting website in August 2025.
- Annual performance data in Excel will be available in the Electronic Reading Room in August 2025.

UDS CQMs AND NATIONAL PROGRAMS CROSSWALK

The following table crosswalks the UDS CQMs and other national programs using these measures. Specification details and eCQM flowsheets are available at the eCQI Resource Center. Use the Office of the National Coordinator Issue Tracking System to report issues or ask questions about eCQM specifications.

ID	Measure Title	Measure Steward	CMS eCQM	NQF #[40]	CMS Medicaid Core Set	Healthy People 2030	MIPS/ QPP	CMIT #[41]
Table 6B, Line 7	**Early Entry to Prenatal Care**	n/a	n/a	n/a	n/a	MICH-08	No	n/a
Table 6B, Line 10	**Childhood Immunization Status**	National Committee for Quality Assurance	CMS117v12	38	Child Core	n/a	Yes	124
Table 6B, Line 11	**Cervical Cancer Screening**	National Committee for Quality Assurance	CMS124v12	32	Adult Core	C-09	Yes	118
Table 6B, Line 11a	**Breast Cancer Screening**	National Committee for Quality Assurance	CMS125v12	2372	Adult Core	C-05	Yes	93
Table 6B, Line 12	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents**	National Committee for Quality Assurance	CMS155v12	24	Child Core	n/a	Yes	760
Table 6B, Line 13	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan**	Centers for Medicare & Medicaid Services	CMS69v12	421e	n/a	n/a	Yes	594
Table 6B, Line 14a	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Physician Consortium for Performance Improvement	CMS138v12	28e	Adult Core	n/a	Yes	596

[40] NQF is no longer the contracted consensus-based entity (CBE) for CMS.
[41] CMS has made the nomenclature change by using CBE numbers available in the CMS Measures Inventory Tool (CMIT).

ID	Measure Title	Measure Steward	CMS eCQM	NQF #[40]	CMS Medicaid Core Set	Healthy People 2030	MIPS/ QPP	CMIT #[41]
Table 6B, Line 17a	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**	Centers for Medicare & Medicaid Services	CMS347v7	n/a	n/a	n/a	Yes	700
Table 6B, Line 18	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet**	National Committee for Quality Assurance	CMS164v7 (no updated eCQM)	68	n/a	n/a	No	405
Table 6B, Line 19	**Colorectal Cancer Screening**	National Committee for Quality Assurance	CMS130v12	34	n/a	C-07	Yes	139
Table 6B, Line 20	**HIV Linkage to Care**	n/a	n/a	n/a	n/a	HIV-04	No	n/a
Table 6B, Line 20a	**HIV Screening**	Centers for Disease Control and Prevention	CMS349v6	n/a	n/a	n/a	Yes	324
Table 6B, Line 21	**Preventive Care and Screening: Screening for Depression and Follow-Up Plan**	Centers for Medicare & Medicaid Services	CMS2v13	418e	Adult Core	MHMD-08	Yes	672
Table 6B, Line 21a	**Depression Remission at Twelve Months**	Minnesota Community Measurement	CMS159v12	710e	n/a	n/a	Yes	190
Table 6B, Line 22	**Dental Sealants for Children between 6–9 Years**	Dental Quality Alliance - American Dental Association	CMS277 (no updated eCQM)[42]	2508 (claims-based measure)	Child Core	OH-10	No	830

[40] NQF is no longer the contracted consensus-based entity (CBE) for CMS.
[41] CMS has made the nomenclature change by using CBE numbers available in the CMS Measures Inventory Tool (CMIT).
[42] Access measure details through the Clinical Care section of HRSA's BPHC UDS Training and Technical Assistance webpage.

ID	Measure Title	Measure Steward	CMS eCQM	NQF #[40]	CMS Medicaid Core Set	Healthy People 2030	MIPS/ QPP	CMIT #[41]
Table 7, Section A	**Low Birth Weight**	Centers for Disease Control and Prevention	n/a	1382	n/a	n/a	No	413
Table 7, Section B	**Controlling High Blood Pressure**	National Committee for Quality Assurance	CMS165v12	18	Adult Core	HDS-05	Yes	167
Table 7, Section C	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)**	National Committee for Quality Assurance	CMS122v12	59	Adult Core	D-03	Yes	204

n/a = Not applicable, NQF = National Quality Forum, MIPS = Merit-based Incentive Payment System, QPP = Quality Payment Program

[40] NQF is no longer the contracted consensus-based entity (CBE) for CMS.
[41] CMS has made the nomenclature change by using CBE numbers available in the CMS Measures Inventory Tool (CMIT).

Appendix I: Glossary

Accrual basis: Method of accounting that recognizes income when it is earned and expenses when they are incurred.

Adjustment: The difference between the health center fee schedule charge and the amount reimbursed by a payer for any given patient service transaction. There may be multiple adjustments on a single transaction.

Aged and disabled former migratory agricultural workers: As defined in section 330 (g)(1)(B), individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of their age or disability.

Bad debt: Amounts owed by a patient that the health center has determined to be uncollectable and has formally written off.

Capitation: An agreed-upon amount that a managed care payer pays to the provider (health center) for providing all of the services in an agreed-upon list. The payer/HMO pays the health center a set amount monthly, regardless of the number of services or if any services were rendered during the month.

Cash basis: Method of accounting that recognizes income when the payment is received and expense when cash is disbursed.

Change in accounts receivable: Charges minus collections minus adjustments, or the amount by which what is owed to the health center increases or decreases during the calendar year.

CHIP: The Children's Health Insurance Program (CHIP) is a federally funded program that provides primary health care coverage for children and, on a state-by-state basis, others, especially pregnant women, mothers, or parents of these children. CHIP coverage can be provided through the state's Medicaid program, contracts with private insurance plans, or both.

Clinical quality language (CQL): A Health Level Seven International (HL7) authoring language standard intended to be human readable.

Clinical quality measure (CQM): A quantified indicator used to evaluate how well the health center is achieving standards.

Contracted personnel: People who work under contract for the health center, as opposed to being a salaried employee. They DO NOT have withholding taxes deducted from their paychecks, and they have their income reported to the Internal Revenue Service (IRS) on a 1099 form.

Cost center: Unit of the health center's accounting where costs associated with that unit are charged and accumulated for accounting purposes.

Countable visit: A documented encounter in the patient health record between a patient and a licensed or credentialed provider who exercises their independent professional judgment in the provision of services to the patient. (Virtual visits are allowable for each of the service categories.)

Denominator: The number below the line in a fraction, or the divisor. As used in clinical quality measure (CQM) reporting, patients who fit the detailed criteria described for inclusion in the specific measure to be evaluated.

Drawdown (noun): The amount of grant dollars in cash transferred by HHS to the health center in response to a formal request for awarded grant funds.

Draw down (verb): A request through the HHS PMS system for awarded and available grant funds to be transferred by HHS to the health center.

Dually eligible: A patient enrolled in both Medicare and Medicaid, with Medicare being the primary insurance.

Electronic health record (EHR)/Electronic medical record (EMR)/Patient health record: A digital record of a patient's registration profile, the history of services provided, diagnostic results, and other patient information. It often includes a web-based communications portal for patients and providers. The record/information is made available securely to authorized users.

Ethnicity: The ethnic ancestry or origin of a person or group of people.

Exclusions or exceptions: As used in clinical quality measure reporting, patients NOT to be considered or included in the denominator (exclusions) or removed if a specific condition is identified (exceptions).

Federal poverty guidelines: An annual notice issued by HHS of the annual income thresholds, defined by the number of persons in the family/household, at or under which individuals are defined as being in poverty. Three separate schedules are issued for people residing in the 48 contiguous states and the District of Columbia, in Alaska, and in Hawaii. Health centers in U.S. territories use the 48 contiguous state schedule.

Fee-for-service: A method of charging for services and paying reimbursements to providers based upon the charge for procedures, visits, or other services rendered.

Fee schedule: A listing of the health center's uniform charges for its goods and services.

First trimester (prenatal care): Women who are estimated to be pregnant up through the end of the 13th week after the first day of their last menstrual period.

Full-time equivalent (FTE): The fraction of time for which an individual is paid during the calendar year. Full-time (as defined by the health center) is equal to 1.00 FTE (and half-time is equal to 0.50 FTE, and so on). FTE may be used in aggregate to describe the availability of a group of personnel in a service category.

Full-time personnel: People generally employed 40 hours per week, but subject to organizational definitions. Full-time personnel generally receive benefits, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W-2 form. Personnel may or may not have a contract. Personnel are full-time when they are so defined in their contract and/or when their benefits reflect this status.

Gross charges: The sum of the full, undiscounted health center fees for a product, a service rendered, or a set of services rendered under a global charge.

Health center scope: A defined set of approved service sites, services, providers, service area, and target populations for a health center.

Hispanic, Latino/a, or Spanish origin: Describes individuals of specific Spanish or Latino/a heritage, lineage, descent, or country of birth.

Homeless: An individual experiencing homelessness is a person who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is at a location classified as unfit for human habitation (e.g., street, field, abandoned building), a supervised public or private facility that provides temporary living accommodations, a day-to-day temporary and unstable living arrangement in someone else's home (doubled up), in transitional housing, or in permanent supportive housing.

Income: Money received through earnings from work and other sources.

Indigent care programs: State or local programs that earmark dollars to pay in whole or in part for services rendered to people who are uninsured and experiencing poverty. Indigent care programs include 638 compact programs for tribal groups.

Last party rule: Reporting of grant and contract cash receipts based on the entity from which the health center received them, rather than the source from which they originated.

Locum tenens: People who work at the health center on an as-needed basis, when the health center is unable to hire full- or part-time personnel until the position is filled, or to serve during a period of increased demand. Locums are uniquely identifiable because they work for an agency and the health center pays the agency rather than the individual. They DO NOT receive benefits from the health center (although they may from the agency they work for) and generally are not covered by the health center's professional liability insurance.

Look-alike: A formal designation by HRSA of a health center that meets the requirements of a Federally Qualified Health Center but does not normally receive Health Center Program section 330 funding.

Managed care: A system in which a fee is paid under contract to a health center by a private or public organization to provide a defined range of services to patients assigned to the health center.

Measurement period: The time period (defined by start and end dates) for which a CQM applies.

Medicaid: Joint federal/state-run programs operating under the guidelines of Titles XIX (Medicaid) and XXI (CHIP, as appropriate) of the Social Security Act.

Medicaid expansion: A program created by the Affordable Care Act that makes Medicaid available to more patients on a state-by-state basis, subject to adoption by the state.

Medicare: Federal health insurance program for people 65 years of age or older, people with blindness, people with a disability, and people with end-stage renal disease (Title XVIII of the Social Security Act).

Member month: One individual enrolled in a managed care plan for one month.

Migratory agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture, who have been so employed within 24 months of their last visit of the calendar year being reported, and who establish for the purposes of such employment a temporary abode. This includes the family members (who themselves may or may not migrate) of the individuals described above and individuals who are no longer employed in migratory agriculture because of age or disability.

National Health Service Corps (NHSC) assignees: Clinicians who either received an NHSC scholarship or are receiving NHSC loan repayment who are obligated to repay that support by serving at an approved facility in a designated health professional shortage area.

New Access Point: A health center's newly approved service delivery site.

New Start: A health center that has received HRSA Health Center funding for the first time during the calendar year.

Numerator: The number that is above the line in a fraction and is divided by the denominator. As used in CQM reporting, patient health records (a subset of the denominator) that meet the criteria for the specified measure.

Off-site contract providers: Providers who are contracted to provide services to referred health center patients at locations other than the health center's approved service delivery sites.

Part-time personnel: People employed for a period less than what the health center defines as full-time. They receive benefits as specified by the health center's policy, have withholding taxes deducted from their paychecks, and have their income reported to the IRS on a W-2 form. Part-time personnel may or may not have a contract.

Patient: An individual who has at least one countable visit during the calendar year in one or more categories of services: medical, dental, mental health, substance use disorder, vision, other professional, or enabling.

Patient service revenue: The revenue attributable to the provision of patient services within the scope of federal project.

Patients' use of services: The extent to which patients accessed available services (see "Services provided" definition).

Penalty/paybacks: Payments made by health centers to refund overpayments, or payments due to failure to meet utilization, failure to provide agreed-upon services, failure to serve assigned patients in a specified time period, or failure to meet other performance goals required by the payer.

Prenatal care (first visit): The first date a patient has a visit with a physician, NP, PA, or CNM who conducts a comprehensive prenatal exam to initiate pregnancy-related health care.

Provider: An individual who exercises independent professional judgment in the provision of services rendered to the patient, assumes primary responsibility for assessing and/or treating the patient for the care provided at the visit, and documents services in the patient's health record.

Public housing: Public housing agency-developed, owned, or assisted low-income housing, including mixed-finance projects but excluding housing units with no public housing agency support other than Section 8 housing vouchers.

Race: A physical or social categorization of an individual, presumably based on inheritance or genetics.

Reclassify (as used in billing systems): Transfer of amounts due from one payer to another payer, including the patient.

Reconciliations (as used in billing systems): Lump-sum retroactive adjustments based on the filing of a settlement report.

Residents/trainees: Individuals in training for a license or certification who provide services at the health center under the supervision of a more senior individual. Many of these trainees (especially medical and dental residents) already have licenses.

Revenue: The money generated by a business before expenses are deducted.

School-based service site: A health center located on or adjacent to school grounds (including pre-school, kindergarten, and primary through secondary schools) that provides health services.

Screening: A test to check for a disease or health condition in the absence of signs and symptoms. Screening tests DO NOT diagnose illness, and those who test positive typically require additional evaluation with diagnostic tests or procedures.

Seasonal agricultural workers: For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, individuals whose principal employment is in agriculture on a seasonal basis and who DO NOT meet the definition of a migratory agricultural worker.

Second trimester (prenatal care): Women who were pregnant and estimated to be between the start of the 14th week and the end of the 27th week after the first day of their last menstrual period.

Self-pay: A payment by a patient that covers (in whole or in part) the cost of services rendered and is NOT directly paid by a third-party payer to the health center for these services.

Services provided: Availability and use of care that a patient may receive from the health center.

Sex: An individual's immutable biological classification as either male or female..

Sliding fee discount: A discount applied to the fee schedule that adjusts fees based on patients' ability to pay based on their income and family/household size.

Standing order: Written protocol that authorizes designated members of the health care team (e.g., nurses) to complete certain clinical tasks without having to first obtain a physician or advanced practice provider order.

Third trimester (prenatal care): Women who were estimated to be pregnant for 28 weeks or longer after the first day of their last menstrual period.

Third-party payer: An insurer or other entity that reimburses the health center for services rendered to patients.

Veteran: Discharged individuals who served in the active military, naval, or air service, which includes the Air Force, Army, Coast Guard, Marines, Navy, and Space Force, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. This also includes individuals who served in the National Guard or Reserves on active-duty status.

Volunteers: Individuals who work at the health center but are NOT paid for their work.

Wraparound payments: Periodic payments to FQHCs to reimburse the shortfall between the amounts paid by the payer and the health center's established FQHC or PPS visit rate.

Appendix J: Acronyms

- ACO: accountable care organization
- ADA: American Dental Association
- ADHC: adult day health care
- AMA: American Medical Association
- AMI: acute myocardial infarction
- API: application programming interface
- APRN: advanced practice registered nurse
- ASCVD: atherosclerotic cardiovascular disease
- AWP: average wholesale price
- BCCEDP: Breast and Cervical Cancer Early Detection Program
- BDI, BDI-II: Beck Depression Inventory
- BDI-PC: Beck Depression Inventory-Primary Care
- BHW: Bureau of Health Workforce
- BMI: body mass index
- BP: blood pressure
- BPHC: Bureau of Primary Health Care
- CABG: coronary artery bypass graft
- CAD-MDD: Computerized Adaptive Diagnostic Test for Major Depressive Disorder
- CADRE: Capital Assistance for Disaster Response and Recovery Efforts
- CARE: Capital Assistance for Hurricane Response and Recovery Efforts
- CASA: Clinic Assessment Software Application
- CAT-DI: Computerized Adaptive Testing Depression Inventory
- CCO: coordinated care organizations
- CDC: Centers for Disease Control and Prevention
- CEO: chief executive officer
- CES-D: Center for Epidemiologic Studies Depression Scale
- CFO: chief financial officer
- CHC: Community Health Center (program)
- CHIP: Children's Health Insurance Program
- CIO: chief information officer
- CIS: change in scope
- CME: continuing medical education
- CMO: chief medical officer
- CMS: Centers for Medicare & Medicaid Services
- CNM: certified nurse midwife
- CoCASA: Comprehensive Clinic Assessment Software Application
- COO: chief operations officer
- COVID-19: coronavirus disease 2019
- CPT: Current Procedural Terminology
- CQL: Clinical Quality Language
- CQM: clinical quality measure
- CSDD: Cornell Scale for Depression in Dementia
- CT: computerized tomography
- DADS: Duke Anxiety-Depression Scale
- DATA: Drug Addiction Treatment Act of 2000
- DEPS: Depression Scale
- DGMO: Division of Grants Management Operations
- DNA: deoxyribonucleic acid
- DO: Doctor of Osteopathic Medicine
- DRE: digital rectal exam
- DT, DTaP, DTP: diphtheria, tetanus, pertussis
- eCQI: Electronic Clinical Quality Improvement

- eCQMs: electronic-specified clinical quality measures
- EHBs: Electronic Handbooks
- EHR: electronic health record
- EKG: electrocardiogram
- EMR: electronic medical records
- EMS: emergency medical service
- EMT: emergency medical technician
- ENDS: electronic nicotine delivery systems
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
- ESRD: end-stage renal disease
- FAQ: frequently asked question
- FDA: U.S. Food and Drug Administration
- FHIR R4: Fast Healthcare Interoperability Resources fourth digital standards release
- FIT: fecal immunochemical test
- FOBT: fecal occult blood test
- FPG: federal poverty guidelines
- FQHC: Federally Qualified Health Center
- FTC/TAF: emtricitabine/tenofovir alafenamide
- FTC/TDF: emtricitabine/tenofovir disoproxil fumarate
- FTE: full-time equivalent
- GAAP: generally accepted accounting principles
- GDS: Geriatric Depression Scale
- gFOBT: guaiac fecal occult blood test
- HAM-D: Hamilton Rating Scale for Depression
- HbA1c: Hemoglobin A1c
- HCFA: Health Care Financing Administration
- HCH: Health Care for the Homeless (program)
- HCPCS: Healthcare Common Procedure Coding System
- Health IT: health information technology
- HEDIS: Healthcare Effectiveness Data and Information Set
- HHS: U.S. Department of Health and Human Services
- Hib: haemophilus influenza type B
- HIV: human immunodeficiency virus
- HL7: Health Level Seven
- HMO: health maintenance organization
- HPV: human papillomavirus
- HR: human resources
- HRSA: Health Resources and Services Administration
- HUD: U.S. Department of Housing and Urban Development
- ICD: International Classification of Diseases
- iFOBT: immunochemical-based fecal occult blood test
- IG: Implementation Guide
- IHS: Indian Health Service
- IPV: inactivated polio vaccine
- IRS: Internal Revenue Service
- IT: information technology
- IVD: ischemic vascular disease
- LAL: Health Center Program look-alike
- LBW: low birth weight
- LCSW: licensed clinical social worker
- LDL-C: low-density lipoprotein cholesterol
- MCO: managed care organization
- MD: medical doctor
- MFQ: Mood Feeling Questionnaire
- MHC: Migrant Health Center (program)
- MIPS: Merit-based Incentive Payment System

- MMR: measles, mumps, and rubella
- MOUD: Medications for opioid use disorder
- NAICS: North American Industry Classification System
- NAP: New Access Point
- NCHS: National Center for Health Statistics
- NHSC: National Health Service Corps
- NP: nurse practitioner
- NQF: National Quality Forum
- OB/GYN: obstetrician/gynecologist
- OMB: Office of Management and Budget
- OMH: Office of Minority Health
- ONC: Office of the National Coordinator for Health Information Technology
- P4P: pay for performance
- PA: physician assistant
- PACE: Program of All-Inclusive Care for the Elderly
- PAL: Program Assistance Letter
- PAP: pharmacy assistance program
- PCCM: primary care case management
- PC-DMIS: personal computer dimensional measurement inspection software
- PCI: percutaneous coronary intervention
- PCMH: patient-centered medical home
- PCV: pneumococcal conjugate vaccine
- PDMP: Prescription Drug Monitoring Program
- PDS: pharmacy dispensing software
- PDSA: plan, do, study, act
- PECS: patient electronic care system
- PHPC: Public Housing Primary Care (program)
- PHQ: Patient Health Questionnaire
    - PHQ-9M: PHQ modified for teens
    - PHQ-A: PHQ for adolescents
- PHS: Public Health Service (Act)
- PMPM: per member per month
- PMS: Payment Management System (PMS-272)
- PPD: purified protein derivative
- PPS: prospective payment system
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
- PRE: Preliminary Reporting Environment
- PrEP: pre-exposure prophylaxis
- PRIME MD: Primary Care Evaluation of Mental Disorders
- PSC-17: Pediatric Symptom Checklist
- PTSD: post-traumatic stress disorder
- QI: quality improvement
- QID-SR: Quick Inventory of Depressive Symptomatology Self-Report
- RBRVU: resource-based relative value unit
- RN: registered nurse
- RV: rotavirus
- SAMHSA: Substance Abuse and Mental Health Services Administration
- SARS-CoV-2: strain of severe acute respiratory syndrome-related coronavirus
- SBIRT: Screening, Brief Intervention, and Referral to Treatment
- SNAP: Supplemental Nutrition Assistance Program
- SRO: single-room occupancy
- SSI: Supplemental Security Income
- TAF/FTC: tenofovir alafenamide fumarate/emtricitabine
- TANF: Temporary Assistance for Needy Families

- TDF/FTC: tenofovir disoproxil fumarate/emtricitabine
- UCR: usual, customary, and reasonable
- UDS: Uniform Data System
- UDS+: Uniform Data System De-Identified Patient-Level Submission
- USHIK: United States Health Information Knowledgebase
- VFC: Vaccines for Children (program)
- VSAC: Value Set Authority Center
- VZV: varicella zoster virus
- WE CARE: Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education
- WIC: Women, Infants, and Children (program)

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